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ORIGINAL LECTURES.

OVARIOTOMY AND OTHER CASES.

A Clinical Lecture,
Delivered at the Rush Medical College, Chicago, Ill.

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[Reported by A. J. OCHSNER, M.D., Chief of Surgical Clinic.]

OVARIOTOMY.

GENTLEMEN: This case is a German girl, aged nineteen years. She is fairly nourished, though rather slight, and with the abdomen enormously distended. She weighs 120 pounds.

Here we have a case showing the development of a large growth in the abdominal cavity, many examples of which we have lately had before us.

I hope you have become impressed with their grave character, and that you will not do anything with them until you have eliminated, as far as possible, the risks of a mistaken diagnosis.

The tumor is everywhere smooth and even. It is prominent, and does not flatten when the patient lies on her back or in any other position. Vaginal examination shows that there is a hard, unyielding mass extending across the pelvis, and as I feel the surface I notice neither roughness nor irregularities. Placing a hand against one side of the prominent abdomen and tapping it on the opposite side with the finger, I feel fluctuation transmitted to the hand. As this can come only through a fluid, I therefore conclude that it is either free fluid in the abdominal cavity termed ascites, or a large cyst with thin walls.

Careful examination has enabled us to eliminate disease of the liver, heart, and kidneys. There has been no œdema or anasarca present at any time. Hence we exclude ascites and are forced, by exclusion and other facts, to the supposition that this is an ovarian cyst. Moreover, this patient has been tapped five times, as much as thirty pints of fluid being drawn with each tapping; in this case doing no injury to the patient. The first time she was tapped the fluid withdrawn was clear, the next, it was darker, and the last time it had the color of beer or coffee. Ascitic fluid is always clear. One danger attending the tapping of such cysts is the introduction of septic material into the abdominal cavity. This may occur either by the instruments used, or by the fluid from the cyst. There is no excuse for the first, and you can often avoid the harmful effects of the contents of the cyst by being sure that the sac is perfectly empty before removing the trocar.

Proceeding with the operation, you notice that I am very careful in dividing the peritoneum, for I do not know the extent of the attachment of the tumor to the abdominal wall, and do not wish to open the sac.

You can see the blue shining appearance of the sac which is characteristic of such tumors. Just here, near the opening into the peritoneum, I find an adhesion which firmly joins the cyst wall to the peritoneum, and the division of which would have made the opening into the cyst cavity instead of into the abdominal cavity. Having enlarged the opening through the peritoneum to the same size as that in the abdominal walls, exposing the sac freely, I now thrust this large trocar into it, choosing a non-vascular portion for its introduction. The fluid from the cyst flows freely, as you notice, but slowly. It is very thick and is cream-colored, looking like pus. If it proves to be pus, there is no doubt that infection came from the trocar needle used in tapping it. Very likely this resemblance to pus will prove to be dependent upon the presence of a fatty substance found in dermoid cysts.

We must not hurry the emptying of the sac, but give it plenty of time and let it empty slowly. Remember that you should not push the ether while you are emptying the cavity, because the sudden release of pressure may so disturb the circulation that the patient in profound anæsthesia may be unable to rally from its depression.

The diagnosis which I have made that this is a dermoid cyst seems to be correct. You see these adhesions: always strip them up so as to break the vessels as far from the base of the adhesion as possible.

In the separation of the adhesions you may use the finger, the scissors, or the knife. The best way is, if they are soft and recent, to sponge them off; if they are stronger, strip them off with the finger; and if they are broad and thick or vascular, you must include them between two ligatures and cut between these. Here, you see, is a large adhesion of the omentum. These others I do not care much about, for they are not very vascular; but this one is quite vascular, and must be tied. I think I shall be able to show you something interesting in this tumor when we open it, for there was a large, hard, bony mass just across the pelvis, plainly felt during vaginal examination. Nothing but a dermoid tumor has such growths in it.

The cases of ovarian tumors I have shown you thus far this month illustrate the differences in abdominal adhesions. The first case had no adhesions; the second, one or two; and this one has practically any number. In perforating the pedicle you must choose the part with the least vascularity. This can be done very easily with the aid of the eye. You do this so that the point of the needle in passing through will not open a vessel that will subsequently bleed. If you use the clamp, never tie the ligature until the clamp is removed, then there will be no danger of the ligature slipping off. I have the pelvis well open before me, and can see that the opposite ovary is perfectly normal. In closing the abdominal cavity, be sure to bring the surfaces together carefully, but do not draw the stitches too tightly.

The interior of the cyst contains a substance which

feels like bone, and is shaped like a lower jaw. In many of these cases the cyst contains bone or other substances, such as teeth and hair. There is a case reported of a dermoid cyst containing nearly 200 teeth. Now, this is what I felt through the vagina.

In order that the patient shall not suffer from the removal of the great weight of the tumor from the abdomen, we will equalize the pressure in a measure by placing a large bunch of cotton on the abdomen and holding it there by means of a bandage.

[NOTE.—A dissection of the tumor showed a bony mass resembling in size and form the bones of one-half of an adult's face, including a portion of the frontal, the malar, and the superior and inferior maxillary bones, the latter bearing partly developed teeth. Progress of recovery normal. Removed stitches on the eighth day, and wound found united. Patient was out of bed two weeks after the operation, and a week later she was able to walk about.]

THORACIC TUMOR.

I now bring before you a woman, aged twenty-four years, who has a tumor on the right side just below the mamma.

I find that she has a good deal of pain, and that she has become somewhat emaciated. Two years ago she was thrown from a horse and had a rib fractured; since that time this tumor has been growing. I am certain that it is a tumor which had best be let alone. The veins on the surface are very much enlarged, and you have already learned that tumors with this peculiarity are usually not very favorable for operation. The exploring needle, you see, does not tell us anything, so we will make an incision. I make this incision slowly, because I do not know what is under my knife. The tumor slides up and down beneath the chest walls. It is so extremely vascular, and in such a position, that we had better not make any further attempt to remove it.

TALIPES EQUINO-VARUS.

You have seen me operate upon so many of these cases that it is scarcely worth while to describe the operation again. This is a case of talipes varus; the toes turn inward. The tendo Achillis is contracted, and the boy walks on the side of the foot. To-day we shall break down the tarsal bones as much as possible, without breaking through the skin. The deformity has been years in reaching its present condition, and you cannot expect it to be cured at once. We will break it down and put in in a plaster cast in the corrected position, letting it remain for one week. Then we repeat this operation until the normal position of the foot is reached. If you listen, you will hear the bones and ligaments break. I very seldom use the knife in these cases, as you know. Having attained a perfect position of the foot, it is necessary to have the patient wear a cast for about a year in order to secure a permanent transformation of the tarsal bones. The patient can walk in his casts without pain or inconvenience.

The next case is a four-year-old brother of the last patient, and has the same deformity. There is nothing hereditary in the deformity, as both parents and five other brothers are well formed. I operate as in the previous case. This method looks cruel, but in my opinion it is by far the best, cheapest, quickest, and surest way of curing club-foot.

NÆVUS OF FACE.

This little boy, aged two years, has, as you see, a small growth near the superior internal angle of the orbit. It is a nævus. I shall remove it by seizing the growth with the forceps, lift it up and clip it off. A little compression will stop the hemorrhage, and then we will apply an iodoform gauze dressing.

NASAL POLYPI.

In this man's nose I can see a growth forcing its way to the anterior nares. He is unable to breathe through either nostril, and you notice as he speaks his voice has a muffled sound. He is suffering from nasal polypi, which are myxomatous growths developing usually from the mucous membrane covering the turbinated bones and, as they grow, hanging into and occluding the nasal fossa. We will remove them by means of this pair of forceps, which are introduced along the septum of the nose, then opened so as to include the growth, and carried up to its base, which is grasped firmly and the polypus twisted off and withdrawn. This is a case where there are a half dozen nasal polypi hanging in a bunch like grapes to their stem. You see we have removed this large one very easily.

CYST OF THYROID GLAND.

This lady, as you see, has a tumor on the neck in the region of the sterno-cleido-mastoid muscle. It is smooth, even and symmetrical, moving with the larynx when she takes a drink. It is a unilateral cystic growth of the thyroid gland. We will introduce the exploring needle and confirm the diagnosis. I get a chocolate-colored, clear serum. The tumor is partially cystic. We will inject it once a week with a five per cent. solution of carbolic acid. This is a simple method, and often followed by cure.

HYPOSPADIAS.

This little boy, aged six years, has the deformity of hypospadias. In this case it can easily be cured by making a transverse cut, separating the fibres holding the penis down, then sewing the opening longitudinally. It is not necessary in this case to interfere with the urethra.

[NOTE. There was much œdema of the prepuce after the operation and severe pain, but elevating the organ and applying hot boric acid fomentations caused this to subside. The organ has been lengthened 1½ inches, and the downward curve has been corrected.]

OSTEOMYELITIS.

The next patient is a man, aged twenty-seven years, who has a suspicious-looking sinus on the inner side of the thigh just above the knee. It looks very much like the external opening of a sinus leading to a localized osteomyelitis. The patient has chosen rather an unfortunate time for coming, as the sinus is apparently closed. We will open it and examine. I am pretty well satisfied that there is a piece of denuded bone somewhere, but I am unable to find it just now. It is a bad plan to open the sinus with the knife, until you have found the bone. We infer that the disease is moderate in extent, and that this is the reason why the bone is hard to find. The pa-

tient breathes badly. Always pay strict attention to your patient under the influence of an anæsthetic. Let your ears be open to every sound, if your eyes are otherwise engaged. You are responsible for what happens to the patient. I shall open this sinus moderately, hoping a little later to find the track leading to the bone. I may not be able to find the bone to-day. Operating in this location requires great care, because of the large blood-vessels in close proximity to the wound. Patience has its own reward—I have found the denuded bone. I have said that this is a circumscribed disease. There has been no involucrum formed. Now my finger rests in a perfectly smooth cavity, and I have no doubt that the patient will get well. I should have abandoned the case for to-day if I had not reached the surface of the denuded bone. Sometimes when these fragments are small they are hard to find, but you should not give up the search.

You will have noticed that we do not use antiseptic fluids except when we have a septic wound, then we irrigate thoroughly with boric acid or other antiseptic solution. The sinus is curetted and the wound packed with iodoform gauze.

[NOTE. The wound healed rapidly, having been transformed into an aseptic wound. About three weeks after the operation the patient returned to his home, the wound being entirely healed.]

TUMOR OF THE FEMUR.

This young man has been before us twice; his thighs are unequal in size. The right thigh is larger than the left, and symmetrical in its muscular development; the left unevenly enlarged a little above the middle. It is tense and hard to the touch, and the muscular tissue seems wasted. I can make nothing out of it but hypertrophy of the femur. I was at first greatly disposed to believe it to be a malignant trouble. All the appearances pointed to sarcoma, but from the healthy appearance of the man I now think it doubtful. He has been taking iodide of potash and is improving, so I will ask him to go on with the treatment and report again.

EMPYEMA.

This young man received a stab-wound five weeks ago, and was brought to us last night. He is very ill, has great pain and a high temperature, and has lost much flesh. There is some bulging of the chest above and behind the stab-wound, which is between the eighth and ninth ribs, just in front of the axillary line, on the left side. The pus flows freely at every expiration through the wound, which had been closed with a stitch at the time of the injury. The blood from the wound might have filled the cavity of the chest without any further trouble, provided the pus microbe had not been introduced into the cavity. This is simply an abscess, an empyema. If the accumulation of pus had been elsewhere in the body, perhaps it would have been treated without timidity by free incision.

This incision which you now see me make through the tissues and down to and through the sixth intercostal space in the line of the angle of the scapula into the chest cavity should have been made weeks ago.

The pus is now escaping freely, and has a most disagreeable odor. Whenever and wherever you find a large accumulation of pus, open it freely. This cavity will be washed out very thoroughly once or twice with a saturated solution of boric acid, and later with hot water. Two large rubber drainage-tubes are drawn through the cavity and left to protrude through both openings, to insure free drainage. A large iodoform gauze and borated cotton dressing is applied. The cavity is to be irrigated daily with a large quantity of pure, hot water until his temperature approaches normal.

[NOTE. During three days following the operation, the temperature fell from 104° F. to normal, and all septic symptoms subsided. Irrigation was discontinued and the patient continued to convalesce, being nearly well on November 14th.]

ORIGINAL ARTICLES.

A CASE OF INGUINAL COLOTOMY FOR CARCINOMA OF THE RECTUM.

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MISS E——, aged forty-eight years, had for some months been troubled with constipation, but had never suffered from pain in the rectum or noticed any discharge of blood or mucus with the stools. I saw her in May, 1889, when she had a more than usually obstinate attack of constipation; and at this time I made an examination of the rectum, but did not discover the presence of any growth or strictures. By the use of laxatives and enemata the constipation was overcome and she had no further trouble until June 10th, when I was called to see her again, and found her suffering from an attack of constipation very similar to the one in which I had seen her before. This attack persisted for some days in spite of treatment, and she soon developed symptoms of obstruction of the bowels; the belly gradually became swollen and tender, and she complained of abdominal pain, but there was no vomiting. I again made a rectal examination, and with the tip of my index-finger I could feel a mass of indurated tissue far up in the rectum, occluding the gut. As the symptoms of obstruction of the bowels were becoming urgent the question of an operation was suggested. Professor Ashhurst kindly saw the patient with me, and after etherizing her I attempted without success to pass a rectal bougie. I now determined to open the descending colon or sigmoid flexure of the colon in the left iliac region, and decided upon the method suggested and practised by Ball, which consists in making an incision in the line of the *linea semilunaris* about three inches in length, with its lower limit just short of Poupart's ligament. This incision was accordingly made, the tissues of the abdominal wall were divided and the parietal peritoneum was exposed and opened, the distended gut presenting itself in the wound; but before this was secured to the edges of the wound the parietal peritoneum was stitched to the skin throughout the wound by fine silk sutures. The presenting gut, which was found to be the upper portion of the sigmoid flexure of the colon, was next drawn well

downward and secured to the edges of the wound by a number of silk sutures, the peritoneal surface of the gut being held in contact with the parietal peritoneum by this means. The distended bowel was next opened by an incision about an inch in length, when a large quantity of semi-fluid fæces and flatus escaped. After the wound had been cleansed of fæces the edges of the intestinal wound were stitched to the skin by a few silk sutures. The wound was next freely dusted with iodoform; a few layers of carbolized gauze were then applied, and a pad of bichloride cotton was placed over this, and the dressing was held in position by an abdominal binder. The patient had a number of copious passages during the next twenty-four hours, and was entirely relieved of her pain and discomfort, and presented no unfavorable symptoms. At the end of the eighth day the sutures were removed and the adhesion of the gut to the abdominal wound seemed perfectly firm. At the end of two weeks the patient was allowed to be out of her bed, and in a short time was able to go about the house and even out of doors. She had a free fæcal movement each morning, and was not often disturbed again during the next twenty-four hours by the escape of fæcal matter, but suffered annoyance from the escape of flatus. After the first week she passed some thin fæcal matter mixed with blood from the anus, and it was found advisable to use an enema of a weak solution of permanganate of potassium occasionally. I saw her frequently, and found her condition as described above. A careful examination of the artificial anus showed no tendency to prolapse of the bowel. The patient continued in a comfortable condition until August 17th—about two weeks after the operation—when she noticed that no fæcal matter escaped from the artificial anus. I saw her upon the following day, and found that the belly was slightly swollen and that she complained of pain in the right iliac region. I introduced my finger into the artificial anus to ascertain if the bowel was occluded by a mass of inspissated fæcal matter, but I found it perfectly clear as far as I could explore it with the finger and a soft catheter. I was called to see the patient on the evening of August 18th, and found her in collapse, and she died in this condition early on the morning of August 19th.

Examination of the region of operation after death showed that the adhesion of the colon to the abdominal wound was firm, the lower portion of the sigmoid flexure, occupied by a carcinomatous growth, was found displaced to the right side of the body, occupying almost the entire right iliac region, and the growth and a number of coils of the small intestine were matted together. At one point the small intestine was opened by ulceration, permitting the escape of fæcal matter into the abdominal cavity.

REMARKS.—In the above case the result of the operation was most satisfactory, both as regards the immediate relief of the symptoms of obstruction of the bowel, and the comfort of the patient, until a new point of obstruction developed by reason of the extension of the growth, which was followed by perforating ulceration of the intestine and a rapidly fatal issue.

Carcinoma of the rectum sooner or later, in the vast majority of cases, leads to stricture of that organ and to the development of symptoms of intestinal obstruction. If, by reason of the situation or extent of the growth, the case is unsuitable for the operation of excision of the rectum or for linear rectotomy, the operative treatment of the affection consists in the performance of either lumbar or inguinal colotomy.

Colotomy relieves the symptoms of obstruction of the bowels, and generally keeps the patient in a comfortable condition until death results from other causes. The influence of the operation in retarding the growth of the disease in the rectum is a question upon which different observers are not fully agreed; some surgeons of large experience in this operation are decidedly of the opinion that following the operation there is a marked retardation of the increase of the rectal growth.

The operation is also in many cases delayed too long; it should be performed before the obstructive symptoms become too urgent, as the immediate risk of the operative procedure is diminished by operating at this time, and there is then an opportunity to delay the opening of the bowel for twenty-four or forty-eight hours, until it has had time to acquire firm adhesion to the abdominal walls, thereby diminishing the chance of fæcal extravasation.

Inguinal or iliac colotomy is the operation which at the present time meets with most favor, and it has the advantage over lumbar colotomy that, by its employment, the bowel is more easily found and the resulting artificial anus is in such a position that the patient cares for himself more readily. In the inguinal operation, moreover, the surgeon can more readily close the lower portion of the bowel if he considers it better to make the artificial anus a terminus instead of a lateral outlet to the bowel.

Prolapse of the bowel is said to be more common after inguinal colotomy than after the lumbar operation, and as this is a condition which causes the patient much discomfort, it should be guarded against at the time of operation by drawing the upper portion of the loop as far down as possible before it is fixed to the abdominal wound.

This is, I think. more important where the operation is done in a case of fibrous stricture of the rectum where the patient's expectation of life is good, than where the procedure is adopted in a far advanced case of malignant disease where colotomy can only be considered at least a palliative procedure.

The tendency to prolapse of the bowel in inguinal colotomy depends directly upon the variable length of the sigmoid mesocolon.

Mr. H. Allingham, to overcome the tendency to

prolapse of the bowel through the artificial anus, recommends the drawing out through the wound of both the upper and lower portion of the bowel until the mesocolon becomes tense; he then passes sutures through the mesocolon and the muscular and serous coats of the bowel to prevent its slipping back. He next applies a clamp with spikes to hold the bowel in this position, which is allowed to remain from twelve to seventy-two hours, according to the urgency of the case; the gut above the clamp is cut off, and if when the clamp is loosened there is no bleeding it is removed permanently. The amount of intestine cut off in some of Mr. Allingham's cases has been as much as twelve inches. I think the incision recommended by Ball, which was the one employed in the previously reported case, is the best one to make use of in inguinal or iliac colotomy. It is an incision about four inches long in the line of the left *linea semilunaris*, which exposes the sigmoid flexure freely and is made at a point where the parietes are thin and no vessels of importance are injured. Whether it is advisable to make the artificial anus a terminus of the gut, by closing the lower portion, will depend upon the conditions which are presented when the abdominal cavity is opened and the gut exposed; if the rectal growth is high up, so that the bowel can be emptied, and if it does not contain much discharge from the growth itself, it is well to empty it and close it after securing the upper extremity of the gut to the abdominal wound. In other cases where there is difficulty in emptying the lower portion of the gut, or where there is free discharge from the growth into the gut, it is better to be satisfied to have the artificial anus act as a lateral outlet to the bowel, as the lower portion of the gut can then be washed out out with some disinfectant solution, if required.

It not infrequently happens, even in cases where the obstruction of the bowels was absolute before colotomy was performed, that the rectum below the growth becomes distended with thin fecal matter and discharge from the growth; this is generally noticed a few days after the operation, and it causes the patient much discomfort and gives rise to a very offensive odor; this condition is best overcome by using, daily, a rectal injection of a weak solution of permanganate of potassium as long as any discomfort is experienced.

HYSTERICAL BLINDNESS OF TEN YEARS' DURATION IN A HEALTHY MALE SUBJECT.[1]

BY GEORGE C. HARLAN, M.D.,
OF PHILADELPHIA.

SIXTEEN years ago I reported several cases of hysterical amblyopia under the head of "Simulated Amaurosis" (*American Journal of the Medical Sciences*, October, 1873), and since then have chanced to meet with a number of cases, some of which have been published from time to time. The subject has been discussed so frequently of late years in journals and lectures and works upon the nervous system, that the excuse for reporting such cases as a warning to be on the lookout for their possible occurrence in female patients no longer exists. The same cannot yet be said where male subjects are concerned, and perhaps it is still in order to remind the profession that this strange psychical whim, or whatever it is, is not altogether confined to the more irresponsible nervous organization of the gentler sex. In one of my first cases the patient was a male, and the following is the report of his case:

A rather delicate-looking boy, æt. eleven years, was represented to have become blind in the right eye about eighteen months before. After the disease had resisted the skill of the family physician for some months, the patient's father was recommended to "try electricity," and took him to a "professor" of that science. The result of one application was an entire restoration of vision. The cure lasted, however, only for a few weeks, when the remedy was resorted to again, with the same result. After this history had repeated itself a number of times, the father, as a measure of economy, invested in an apparatus of his own, and wound up his son's vision as often as it ran down.

When brought to the Wills Hospital, the boy asserted that the eye was not conscious of the ophthalmoscopic examination, which, however, revealed nothing to account for the loss of sight. When a prism was placed before the left eye he admitted seeing two images of the gas-jet, which could easily be distinguished by a colored glass or made to unite by a corrective squint when the base of the prism was held outward. He was required to read with the prism still before the eye, and while he was disconcerted and thrown off his guard by being urged to read rapidly, a fold of paper was slipped in front of the left eye and he continued to read with the right. The father was quite sure that there was no motive for the deception. The fact that the boy's mother was blind in the right eye was a singular coincidence, and, perhaps, may have had a psychological bearing in the case.

About the same time I met with the report of a case by Galezowski, of Paris, in which the patient was also a boy, eleven years of age. Galezowski considered it a plain case of malingering; and in my own report I spoke of the pretended blindness as a deception. What I have since seen in other cases convinces me that we both may have been wrong, and raises a strong doubt in my mind whether either of these patients could have seen by conscious effort with the eye supposed to be blind.

No other instances of this affection occurring in males have come to my knowledge until Dr. William A. Moore reported three cases at the last meeting

[1] Read before the American Ophthalmological Society.

of the American Ophthalmological Society, and Dr. Edward Jackson referred to one that had recently occurred in his practice. Another has since been reported (*New York Medical Journal*, February 9, 1889) by Dr. Marlow. The following case presents several points of interest other than the sex of the patient:

A tall, well-developed man, twenty-two years of age, a clerk in a railroad office, living some distance from Philadelphia, came to me in March last with the following history: Ten years ago, while walking in the street, he was struck on the right eye with a stone thrown by a boy. Considerable pain and inflammation followed the injury, and the sight of the eye was lost. He was for several months under the care of a well-known ophthalmic surgeon, and finally discharged as incurable from supposed paralysis of the optic nerve. His eyes had since been a constant source of anxiety to his parents, and had proved a serious interruption to his education. He had recently suffered considerable eye-strain and frontal headache after work at his desk, which had occasioned him much uneasiness, particularly as his family physician had assured him that it might be necessary to have the blind eye removed to save the other one. Under these circumstances he came to Philadelphia for special treatment, quite ready to submit to enucleation if it should be advised.

In the left eye V. $= \frac{20}{XX}$, and no manifest hypermetropia. Ophthalmoscopic appearances normal. In the right eye, he stated that there was no light-perception—that he was not conscious of the light-reflection from the ophthalmoscopic mirror; but the appearance of the eye was natural, the pupil responded to light, and the ophthalmoscope showed absolutely nothing abnormal but a low degree of hypermetropia. His appearance and manner were so utterly at variance with any suggestion of hysteria, or any kind of nervous derangement, that the suspicion of it did not at first occur to me. At the second visit, with both eyes fully under the effect of homatropine, ophthalmoscopic examination gave the same negative result as before. The mydriatic revealed a latent hypermetropia of 1.25 in the left eye, which had been the cause of the asthenopic symptoms. As a last resort, a prism with base down was held before the left eye, and, to my surprise, double images of a gas-jet were at once admitted. This, of course, proved that both eyes saw; how well the right could see was easily shown by a simple test which has never yet failed me in similar cases. A + 1.25 glass, which merely corrected the error of refraction, was placed before the right eye, and before the left a + 4 D., which excluded that eye from distant vision without the knowledge of the patient, and he was directed to read the test letters at twenty feet. He read No. 25 without hesitation—of course, with the blind eye. I then closed the left eye and called his attention to what he was doing. His surprise was equalled by his joy at the discovery, and both were evidently genuine. There was no suspicion in my mind of a conscious deception on his part; in fact, he had been ready to seal his good faith by the sacrifice of his eye.

Interesting points in this case are the long continuance of this imaginary disease and the entire absence of any other symptoms of irregular nervous action. After remaining firm in the belief of his blindness for ten years, there is no reason why he might not have carried this imaginary burden through the remainder of his life. The patient himself considered his general health to be perfect, and his uncle, a well known medical practitioner, assured me that he had not only always been free from any other suggestion of hysteria, but that he knew of no young man in whom he would be more surprised to find symptoms of nervous derangement.

The behavior of the pupil should have excited suspicion of simulation at once, as prompt pupillary reflex in a blind eye may be considered a physiological paradox. My excuse for not having entertained this suspicion at first is the apparent absurdity of that view of the case when the history and present condition of the patient were considered. That the converse does not always hold—that a perfectly immovable pupil is not positive proof of something more than hysteria—was shown by a typical case of hysteria that I reported to the Ophthalmological Society in 1884, in which a widely dilated and fixed pupil was one of the symptoms promptly relieved by the application of a wooden imitation of a magnet.

THE POST-MORTEM IMBIBITION OF POISONS IN ITS MEDICO-LEGAL BEARINGS.[1]

BY JOHN J. REESE, M.D.,

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THE phrase—*post-mortem imbibition of poisons*—literally signifies the imbibition of poisons into an animal body after death. To the toxicologist, however, it has a more distinct, specific meaning—namely, the infiltration into the different organs and tissues of the body of a poison which has been introduced after death either into the stomach, the rectum, the abdominal or the thoracic cavities, and which has subsequently penetrated by transfusion into the adjacent viscera.

The whole scientific interest and importance of this subject centre in the fact so essential to the toxicologist—that in his search for a poison in a dead body, in a criminal case, the grand object of the analyst is not merely to discover this poison in the stomach (since there is always the *possibility*, at

[1] A paper read before the Medical Jurisprudence Society, of Philadelphia, by special request at the stated meeting Nov. 12, 1889.

least, of its having been introduced here after death), but rather to detect its presence in the various organs and tissues of the body, as the liver, kidneys, spleen, heart, lungs, brain, spinal cord, and even the muscles and bones, into which it had been carried and deposited by the circulation during life, and where its remains may often be discovered a long time after death.

Now, the detection of this *absorbed* poison—as it is rightfully named—in any of the organs of a dead body has hitherto been universally regarded as the most positive and satisfactory proof that the poison had been taken during life, and that it was undoubtedly the real cause of the death, in the absence of all other obvious causes, revealed by the post-mortem examination. Certainly, it would seem, there could be no other legitimate conclusion. But it will be at once apparent that if it can be shown that by introducing a poisonous solution into the stomach, rectum, abdominal or thoracic cavities, or bloodvessels, *after* death, this solution will pass through the walls of these cavities, by the well-known physical law of osmosis, or transfusion, and will gradually but surely penetrate into the adjacent viscera—first into the nearest ones, and subsequently into those more remote, so as to be discovered in them by chemical analysis; then I submit that a most serious and vital difficulty might present itself, fraught with no little danger, namely, the risk of confounding or mistaking the one condition for the other, in a case of alleged criminal poisoning, where the issues of life and death are at stake, and where the evidence for conviction might be dependent chiefly or solely on the chemical analysis. For, as is evident, there is absolutely nothing in chemistry alone to distinguish between them; the same tests must be applied to both, and they must yield the same results.

Those persons who have given no special attention to this subject may be surprised to learn that such a question should ever be raised in a criminal trial for poisoning; but cases not a few have occurred, and their number is increasing, where the whole question of the guilt or innocence of the prisoner may hinge simply upon this very point—whether the poison that has been discovered in the organs of the deceased may not possibly have been first introduced into that body after death, for a wicked and fraudulent purpose—either to create a false impression that the deceased had actually been poisoned, although his death had been correctly attributed to other and natural causes, or else in a case of actual criminal poisoning, where the guilty criminal has sought to cover up his work, and escape detection, by injecting the same poison into the body of his dead victim (for example, a solution of arsenic, or of corrosive sublimate) under the specious guise of embalming or preserving the body; but, at the same time, armed with the guilty knowledge that the poisonous liquid thus introduced would speedily be diffused through the different organs of the body, and would thus render abortive the subsequent attempts of the toxicologist to prove that the death had been caused by poison. Cases of this latter character have more than once been brought to my notice.

The bare fact that a dead body may imbibe a poison was first clearly demonstrated by Orfila, more than sixty years ago, by experiments made first on the bodies of the lower animals, and then upon the human body. He found that when a mineral solution was injected into the stomach or rectum after death, it was speedily diffused throughout the various viscera; the completeness of the diffusion and the number of the organs affected being always in proportion to the strength of the poisonous solution, and the length of the interval between the injection and the examination of the body. This is precisely what we might have expected.

Orfila also distinctly exposed the fallacy of the prevalent popular idea that a dead human body might possibly absorb the poison if buried for a long time in an arsenical soil. Now, as this is a question of some medico-legal importance, I will dwell upon it for a moment. It is well known that the soil of certain cemeteries contains traces of arsenic—more frequently in Europe than in this country. Hence it occasionally happens in a trial for alledged arsenical poisoning, where the evidence against the accused is chiefly of a chemical character, that the counsel for the prisoner, driven to extremities, will take refuge in the now exploded idea that the arsenic found in the body of the deceased was really due to absorption from the soil of the cemetery, more especially if the body had been interred for many years, so as to have given time for the coffin to fall to pieces, and the remains to come into actual contact with the poisoned soil.

But, as I have just observed, Orfila distinctly proved the fallacy of this notion. He showed by experiments that imbibition from an arsenical soil can never happen, and for the very sufficient reason that the arsenic existing in the soil of cemeteries is never in a soluble state, and consequently could never be absorbed. This opinion of Orfila is now universally adopted by toxicologists; and I believe that no well-instructed criminal lawyer of the present day would hazard his reputation by urging such a plea before a court and jury.

The experiments of Orfila already alluded to, to prove the *fact* of the imbibition of poison after death, have since been frequently repeated by other investigators, among whom is myself. Some years ago I instituted a series of experiments at the University of Pennsylvania, or rather I supervised those

made at my suggestion by Dr. George McCracken, of this city, a member of my class. My paper, containing the results of these experiments, was read before the College of Physicians of Philadelphia, and was published in its *Transactions*, 1877.

The animals whose bodies were employed were cats and dogs. The poisons used were solutions of arsenious acid, corrosive sublimate, and tartar emetic. These were injected through a tube, into the stomach, and the bodies were then buried in the earth for periods varying from three to seven weeks. On subsequent examination the clearest possible proofs of the diffusion of the poisons into adjacent viscera were afforded; they were detected in the lungs, diaphragm, spleen, kidney, heart, and urinary bladder, by chemical analysis; and also rendered visible to the eye by the deposit of characteristic colored spots of the respective sulphides in the peritoneum and mesentery—*yellow* in the case of arsenic, *orange* in that of antimony, and *black* in that of mercury. These experiments also confirmed another fact mentioned by Orfila, namely, that this post-mortem imbibition is progressive, depending upon the length of time elapsing between the injection of the poison and the examination of the body.

I regret to say that at this time no examination was made by me of the brain and spinal cord; because I did not, at that date, believe that a poison thus imbedded could possibly pass through so many intervening tissues, and at last penetrate the thick bony casements enclosing the brain and spinal marrow. Moreover, at that time no experiments had been made to ascertain this fact; and I then even ventured to express the opinion that such a result could hardly be expected; so that the discovery of a poison in the brain or spinal cord after death might be regarded as pretty sure proof of ante-mortem poisoning, whilst its detection in any of the other organs could not be received as such incontrovertible evidence, inasmuch as they might possibly have become contaminated by a post-mortem imbibition.

But certain experiments conducted subsequently to my own, especially those by Dr. George B. Miller, of this city, another member of my University class, and by Professor V. C. Vaughan, of the University of Michigan, and others, seem very positively to establish the fact that *arsenic* certainly (and other poisons presumably) does really reach both the brain and spinal cord after previous injection into the stomach of a dead animal. I have as yet no data to prove that this result would follow the injection of the poison into the rectum, or into the abdomen or thorax, but I have very little doubt that such would be the case.

Thus it has happened that this lately ascertained fact, although deeply interesting from a scientific point of view, proves to be unfortunate in another respect, inasmuch as it destroys completely what otherwise would have been a most valuable and trusty means of diagnosis.

We all know that it is much more difficult for the toxicologist to detect the poisonous alkaloids—strychnine, morphine, nicotine, etc.—in the organs after death, in a case of genuine ante-mortem poisoning, than it is to discover the mineral poisons, arsenic, mercury, antimony, lead, etc. Of course, the difficulty would be proportionately increased in the attempt to detect these alkaloids in the viscera when injected into the body post-mortem. So far as I am aware, no experiments in this line have been made, or, at least, have not yet been published, until those recently performed by my friend, Dr. Miller, whom I have already quoted. He has within the past few years made a series of investigations to test this fact, more particularly with the alkaloid strychnine, taking it as a type of the alkaloids. He has kindly exhibited to me the results of his experiments, which were performed upon the dead bodies of rabbits. A strong solution of strychnine in water (ten grains to one fluid-ounce) was carefully injected into the stomach by means of a tube passing through an incision made in the œsophagus, this mode of injecting being adopted in order to avoid any possibility of the poison regurgitating from the syringe through the posterior nares, and thence through the sphenoid and ethmoid cells directly into the brain. The animals were examined at various periods after interment, varying from twelve days to several weeks; and, as the result, Dr. Miller feels perfectly sure (and I can see no reason to doubt the accuracy of his results) that he has detected strychnine imbibed post-mortem in the *liver*, *spinal cord*, and the *urine* remaining in the bladder. In the brain, however, he has not, thus far, succeeded in finding it.

I think, then, that we may regard it as an established fact that *all* poisons—organic as well as mineral—at least all those susceptible of solution, do undergo the process of imbibition or transfusion into the various organs and tissues of a dead body; and, further, that in every criminal trial for poisoning this important fact should always be kept in view for the benefit of the accused, and that in every toxicological examination of a dead body the possibility of the post-mortem transfusion should never be forgotten.

We are now naturally led to consider the important question whether there is any means by which, in the case of death from alleged criminal poisoning, we can positively discriminate between the poison administered before death and that which may have been injected into the body designedly after death. This is, of course, a question of momentous importance. Several cases have come to my knowledge where the whole question of the guilt or innocence

of the accused hinged on this very point. For instance, an old man has died from some ordinary disease, but with no symptoms leading to the suspicion of poisoning. Previous to his death he had made a will, bequeathing the bulk of his property to his housekeeper, whom he had lately married, and leaving his children comparatively penniless. Now, these disappointed heirs restrained by no moral principle, might determine to thwart this unnatural act of their father, and to effect their wicked purpose they hesitate not to hatch a most diabolical scheme, viz., to charge the woman with the horrid crime of poisoning her husband for the purpose of obtaining his money. Armed with the fatal knowledge of the post-mortem imbibition of poisons, they secretly gain access to the buried body of their parent, and with no great difficulty succeed in introducing a solution of arsenic into the stomach, and, after quietly waiting for a few weeks or months, they begin to whisper the suspicion that there was a mistake as to the cause of the old man's death, and that there was a strong suspicion that he had been poisoned. This allegation would be rendered the stronger if any of the symptoms at the time of his death had happened to resemble those of an irritant poison. Very soon the tongues of gossip and slander would spread the flame of suspicion throughout the community, until it reached the ears of justice, when, forthwith, the exhumation of the body and an judicial examination follow. As the result of the latter, the presence of the dreaded arsenic is discovered in the different viscera of the body. And what follows? Sad to relate, the arrest and possible conviction of a perfectly innocent woman, around whom has been insidiously woven a net of suspicious "circumstances," through the meshes of which it seems almost impossible for her to escape. This is no mere fancy sketch; its counterpart is believed to have occurred more than once.

But take another illustration, of an altogether different nature, and one much more likely to occur. A husband, prompted by some base motive, determines to get rid of his wife by poison. It is administered to her secretly, and in small doses, so as gradually but surely to accomplish the desired end. The physician who may be called in, as well as the attendants upon the sick woman, may be entirely deceived as to the real condition of things, and the poor victim is treated for some supposed disease, until death ensues. Immediately afterward the designing husband, with a full knowledge of the consequences, and under the specious pretence of embalming the body of his wife, injects into the abdomen a strong arsenical solution—such as is often used by undertakers. Or, perhaps, he may even employ a physician or an undertaker to perform the job. The body is then duly buried, and the guilty husband hopes that his villany has been covered up; for, even if subsequently suspicion should be excited, and the wife's body should be disinterred and examined for poison, its detection in the different organs and viscera by the toxicologist might, as we have seen, be readily ascribed to its post-mortem imbibition, resulting from the embalming liquid. Again the important question presents itself—how are we to discriminate in such awfully intricate cases, in which the innocent may be made to suffer and the guilty may escape free? I answer, not by chemistry merely, since the results of a chemical analysis must necessarily be the same in both cases.

There are some considerations, however, which may possibly tend to throw light upon this confessedly intricate subject. As now understood, in every case of death from actual poison a careful toxicological examination of the body will usually reveal the remains of the poison which has been absorbed and retained by the different viscera, more especially by the liver and kidneys. In any such case, it is noted that the interior of the organ contains quite as much of the poison as the exterior, because it has been deposited there by the capillary bloodvessels during life; whereas, in a case where the organ has been contaminated by a post-mortem imbibition of a poison, the exterior of the organ should indicate a larger amount than the interior, and for a reason obvious on a moment's consideration. This may be regarded as one factor of the diagnosis, although perhaps not a very strong one.

Another circumstance worthy of greater consideration, although I believe it has never yet been thoroughly worked out, is that there is, probably, a histological and pathological change wrought in the tissues and organs impregnated with certain poisons, and visible only under the microscope. This alteration would be likely to occur only as the result of absorption of the poison into the circulation during life, and not from mere physical transudation after death. It is now well known that in cases of slow poisoning by arsenic, lead, and other metals certain neurotic symptoms are developed, accompanied by well-marked pathological lesions in the great nerve centres. In an address by Dr. Formad, of Philadelphia, before the International Congress of Medical Jurisprudence, lately convened in New York, upon this very topic, the opinion was expressed that there is always a very decided histological and pathological alteration in the mucous membrane of the stomach (he does not mention any other organ) produced by true arsenical poisoning, and differing from that caused by corrosive sublimate. He further asserts that "poisons introduced into the dead body do not induce any histological changes in the tissues whatever." This I believe to be the true direction

in which to seek for the solution of this vexed question—the histological and pathological changes wrought in the tissues and organs by an ante-mortem poison; indeed, it may be regarded as the crucial diagnostic test, so far as it goes. We have, as yet, no evidence whatever of its application to the organic poisons.

But here I would guard against an error held by some, that any mere pathological alteration discovered in a stomach after death is sufficient, of itself, to warrant the conclusion of death by poison, and this for the simple but sufficient reason that these same pathological changes are often produced by disease. I admit there may be a very few exceptions to this view, as, for instance, in poisoning by the strong mineral acids or alkalies; but with these exceptions, I should consider it extremely hazardous, in a capital case, to found an opinion as to death by poison *solely* on the post-mortem appearances of the stomach.

A third factor in the diagnosis is the examination of the urine *before* death in a suspected case. This examination ought never to be neglected by the attending physician. An analysis of the urine after death—especially long after death—is much less satisfactory, since it has been shown that a poison may penetrate from the stomach into the urinary bladder by a post-mortem imbibition, and so contaminate the urine.

After all, we must be compelled in such cases to fall back upon what are termed the "circumstances" of the case. One of the strongest of these circumstances is the symptoms manifested by the deceased before death. As is well known, most of the violent, irritant poisons, when taken in fatal doses, are accompanied by well-marked symptoms, which, to an experienced observer, are very suggestive. But it should be remembered, they are *merely suggestive:* they do not convey absolute *proof* by any means, because these very same symptoms are sometimes simulated by disease. Thus I have, more than once, found large quantities of arsenic in the bodies of persons who were supposed to have died from cholera morbus, and who had been treated by physicians for this disease, and the cause of their deaths so certified by the physicians, so closely do the symptoms in both conditions resemble each other. But if the poison has been administered in small doses at intervals, then the symptoms are altogether different, and they may very readily be mistaken for those of some insidious disease.

And, finally, under this head, I should not omit to allude to those "circumstances" which, when they do occur, constitute a most important link in the chain of evidence: such as the existence of a strong impelling motive to the deed, on the part of the accused, or of some interest he may have had in the death of his victim—as, for example, the obtaining of a life-insurance claim. Likewise, the proofs of the purchase and actual possession by the accused of the very poison discovered in the body of the deceased; and, possibly, also the discovery of some implements belonging to the accused, such as, it might even happen to be, the very syringe and tube employed by him to inject the poisonous liquid after death, with enough of the remains of this liquid still adherent to the implements to be recognized by the toxicologist.

All these and many other such "circumstances" constitute invaluable material which an astute and judicious counsel will not fail to work up into most important testimony, either for or against the prisoner.

From what I have said, I think all must be impressed with the importance of the subject of the *post-mortem imbibition of poisons*—especially to the toxicologist and the legal physician. My own mind has been especially directed to it in its relation to the unauthorized and indiscriminate use of poisonous mineral liquids, injected into the bodies of the dead, for the purpose of embalming or preserving these bodies, by several cases lately brought to my notice which occurred in neighboring States, and in which the ends of justice were completely foiled by this pernicious practice. In two of these cases the poisonous compound was injected soon after death into the abdominal cavity by an undertaker, apparently without any authority, or orders, but solely to follow out his own ideas, or to carry out his usual custom. Now, in both these cases, there was a strong suspicion of death by poisoning. I would ask, does not an undertaker by such unauthorized action, although perfectly innocent of any guilty connivance, render himself liable to a very strong suspicion of such guilty complicity? And might not even an innocent physician, performing this operation in kind compliance with the request of the real poisoner and, of course, without any suspicion of the true cause of death, thus subject himself to the terrible consequences of being accessory to the crime? The third case which was referred to me—strange to say, from the same State—was that of the wife of a clergyman, who had died under strong suspicions of poisoning by arsenic. The husband, very soon after the death, caused an arsenical solution to be injected into his wife's body, ostensibly with a view of preserving it, but doubtless with the intention of thwarting the ends of justice by thus rendering the proof of poisoning impossible. The case was rendered stronger by the fact that this clerical Bluebeard had previously lost several wives, two of whom under precisely similar circumstances. The case, I learn, is still held under advisement, as the husband was not as yet under arrest, in consequence of certain family reasons.

Now, with a full knowledge of the above cases,

and impressed with the danger and risk incurred by the community by this indiscriminate and unauthorized injection of dead bodies by undertakers and others, I some weeks ago sent a communication to our Board of Health, drawing their attention to the danger of allowing such indiscriminate embalming of the dead without proper authority, remarking, however, that I was not aware of any such cases occurring in this city, but that I knew of them elsewhere. My communication was intended to be merely precautionary: to call attention to an evil that did exist elsewhere, and which it was desirable to prevent getting a foothold here. I suggested the passage of an ordinance forbidding any undertaker, physician, or other person whatever, injecting any poisonous or embalming fluid into a dead human body, without proper authority, except for the preservation of subjects for dissection in medical colleges. I was glad to learn from a somewhat vigorous protest from one of our undertakers that such an indiscriminate use of embalming fluids was *not* common in this city. Still, the passage of such an ordinance might certainly be productive of good, since I have the most positive evidence that the practice alluded to is very common in other parts of our country.

THE CLIMATIC TREATMENT OF GASTRO-INTESTINAL DISEASE IN CHILDREN.

BY BOARDMAN REED, M.D.,
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CLIMATIC treatment can at present be carried out only by transporting the patient to some locality having a different climate. The time may come when a change of air (which is not all there is, however, in a change of climate) may be obtained by conveying to sick-rooms in the cities various qualities of air through pipes from the seashore, country, or mountains, as coal-oil is now sent to market. The physician of that future golden age may then prescribe for his patients a special kind of air as readily as water from a certain spring, and the nurse can have it turned on just as she now does gas, water from the spigot, or hot air from the register.

Why does a change of air often effect such striking remedial results? The question has never been satisfactorily answered.

When a sick child is removed from the hot, stifling, and germ-polluted air of a great city in summer to any comparatively cool and healthful place, there are reasons enough why marked improvement results. But when a weakly infant resident in the most salubrious mountain home contracts diarrhœa from improper feeding or imprudent exposure to extremes of heat or cold, and the disease runs a slow course, a change to the seashore will usually have a like beneficial effect. Then, when the same thing happens to a child resident at the shore, a change to the moutains may be equally helpful.

We can only infer that in such cases the breathing of a different air acts as a stimulant to the vital processes. The probability is that there are ingredients peculiar to the atmosphere of every locality that have a tonic effect at first, until, like too long a course of quinine or other roborant drug, they cease to stimulate. Then, upon taking the patient to another climate, other tonic ingredients are inspired, with at first an invigorating and restorative effect as before.

Some such varying substances there must be in the air of every region, whether they are gaseous elements unrecognized by the chemist, or only coarser material particles held in suspension, as certain amounts of saline constituents are known to be held in suspension in sea air.

When recently requested to write a paper on the climatic treatment of cholera infantum, I objected that the subject was too restricted. Another reason for desiring to enlarge its scope to "gastro-intestinal disease in children" was that at the seaside resorts where most of my clinical experience has been acquired, cholera infantum is a rare malady, and, that therefore, I am less familiar with that affection than with most others that afflict babyhood.

Its later stages and its results I see very often, since it is exceedingly common for infants to be sent to the seashore as soon as the violence of the attack is over, whether the after-condition is a subacute or chronic entero-colitis, or one of slow convalescence with great debility.

But no case of genuine cholera infantum has occurred in my practice at Atlantic City for at least four years. It may be only a coincidence that for about the same period of time the town has had an excellent water supply, and a system of effective underground sewerage in full operation. During the preceding years, when its sanitary condition was less perfect, cholera infantum, though very infrequent, was met with by me occasionally.

Evidently the best treatment for the graver forms of "summer-complaint" is the preventive one, and the best method of prevention is to take teething infants away from the large cities before the hot season begins. One of the recognized authorities on this subject[1] says: "People with means avoid the dangers of summer diarrhœa by taking their children to the country, seashore or mountains, where the air is uncontaminated, the heat less intense, and the milk pure."

When such preventive treatment has been neglected and one of the dreaded summer maladies has attacked a child, change to a more salubrious

[1] Starr: Diseases of the Digestive Organs in Children, page 181.

locality is still usually possible. In the earlier stages of cholera infantum removal to a distance is not often practicable; but later on, after the equilibrium of the circulation has been somewhat restored, no remedy is more efficient for the resulting dangerous prostration—whether accompanied by diarrhœa or not—than a transfer to some cooler and purer atmosphere. The most beneficial change in such cases is either to the mountains or seashore. Either answers well in the majority of cases, and the relative proximity or convenience of access often, properly enough, decides the choice. No complicating conditions could contra-indicate the seashore, except advanced phthisis, but infants with organic heart disease or seriously enfeebled circulation should not be taken to very high altitudes.

The more stubborn subacute and chronic intestinal fluxes, which in infancy may generally be classed pathologically under the term *entero-colitis*, are the most important of the affections now under discussion. They cause every summer a frightful mortality. Fortunately change of climate may not only be resorted to in advance with a reasonable certainty of preventing them, but may be employed also as the most efficacious means of cure in attacks that have resisted treatment at home.

When children wasted and debilitated to the last degree with diarrhœa are removed to a favorable locality by the sea, such as Atlantic City, concerning which I can speak definitely from a long personal experience, the result is usually a prompt and surprising improvement, which in some cases seems well-nigh miraculous.

The pale, languid, and emaciated little sufferers brighten up with the first whiff of the salt air. Peevish restlessness and wakefulness soon give place to quiescence and sound refreshing sleep. The flagging pulse rallies and becomes stronger. The appetite improves; food is better retained and better digested. In consequence there is a tendency to an improvement in the character and diminution in the number of the evacuations. The hollow eyes assume a more natural expression, and the shrivelled limbs grow plumper.

All this may, and often does, result from the stimulating effect of the change of air alone. More frequently, however, such patients require skilful medical attention as well as the best of nursing for the first few days at least.

This is not the place to discuss methods of drug treatment, and, therefore, I shall not go into that matter further than to mention *en passant* that small doses of creasote, carbolic acid, or mercurials, minute doses of arsenic or podophyllin, and moderate doses of bismuth or naphthalin, nearly all having decided antiseptic powers as well as a special action upon the alimentary canal, are prominent among the remedies that have usually accomplished the best results in my hands. In the more recent cases one laxative dose of rhubarb or castor oil has generally proved efficacious as a preliminary measure; and in all cases with much weakness of the circulation, brandy, digitalis, or other cardiac tonic has, of course, been a necessary adjunct.

In the management of these infantile diarrhœas certain hygienic precautions are always important. The flannel belly-band should never be left off, especially at the seashore. The food and drink should be rendered as nearly aseptic as possible. Even with the excellent water now obtainable at Atlantic City, and the fewness of disease germs in the air as compared with that of the large cities, I advise the boiling of all water given to sick babies, whether as drink or mixed with their food.

Infants suffering with entero-colitis are, in nine cases out of ten, bottle-fed, and besides requiring that the bottles and nipples be kept chemically clean, never countenancing, of course, such abominations as rubber tubes attached to the nipples, it is necessary that all forms of artificial food should by some means be rendered aseptic.

Cow's milk, when given to teething infants in warm weather, should be boiled as soon as obtained and then preserved in corked bottles or tightly covered vessels; or better still, the now familiar sterilizing process may be resorted to. It should be borne in mind, however, that except when the milk can be obtained directly from the cow, it is never very fresh, and rarely entirely unaffected by the injurious changes which begin in it as soon as it comes in contact with the air. When from twenty-four to forty-eight hours old, as it usually is when obtained from the dealer, it is such a dubious food, that it may be doubted whether in hot weather any process of sterilization or even peptonization can render it entirely safe and wholesome for sick children. And according to the results of my investigations, it is quite exceptional that the ordinary commercial milk, either in the city or the country, is less than twenty-four hours old when delivered to the consumer. By special arrangement it is sometimes possible to procure it on the same day it leaves the cow, especially when access can be gained to the owner of the animal.

The practice of sending to market directly from the dairy-farm fresh milk carefully put up in sealed air-tight jars, is coming into vogue, and probably in the near future an abundant supply of this kind can be obtained. With such milk the problem of infant feeding will have been greatly simplified.

For some time past, in treating infants in July and August, unless fresh milk could be had from the owner of one or more healthy cows, I have usually made a trial of the least sweet brands of condensed milk variously combined as the case seemed to require. Such trials have rarely disappointed me.

With care to use only a fresh article, and to add to the solution a certain proportion of lime-water, together with, in some cases, barley-water or rice-water, I have seen in midsummer much better results than with any other lacteal combination. At other times of the year, and at any time when the baby and milk-giving animal can be brought near together, I consider good fresh milk, properly diluted and sometimes strengthened with cream and milk-sugar, to be usually preferable to condensed milk or any of the patent infant foods.

An important point in this connection is, that acute gastro-intestinal affections in infants will often respond much more satisfactorily to any treatment, climatic or medicinal, or both combined, if at the outset the patient be deprived of every form of milk for one or two days. The discovery in milk of tyrotoxicon and its highly poisonous action afford a sufficient explanation of the observed clinical fact that in stubborn cases of infantile diarrhœa suitable antiseptics, with a preliminary dose of some laxative —to antidote and sweep out the toxic remains of decomposed milk—will frequently accomplish better results than astringents, and that withholding lacteal food of every sort for a few days is sometimes an indispensable condition of cure. Gum-water, barley-water, chicken-broth, egg-water, a mixture of Bovinine or Murdock's Food with water, and, for older children, stale bread or toast crumbled in the juice from steak or roast beef, are among the substitutes which have often agreed well with my little patients.

In the care of these cases at the seashore it is important to pay more attention to the clothing than is necessary in the cities. This needs to be warmer, particularly at night and when the child is kept at the beach, as it should be the larger part of the time. Improper feeding, and especially over-feeding, often produce relapses at the shore, as they do everywhere. When there is much vomiting, the bottle should be taken away for a time and nourishment administered at frequent intervals by the tablespoonful, or even teaspoonful. When the child is in a hotel or boarding-house, or at points on the beach where many persons pass, it should be protected from the annoyance of being stared at by strangers, an infliction which frets some infants exceedingly. A child worn out by a long siege of diarrhœa has no nerve-strength to be wasted, and all such disturbing causes add to the exhaustion.

Exceptionally, these little patients fail to improve even in the most favored localities, but my later experience is to the effect that when they are sent to Atlantic City before their heart force is so far gone as to be incapable of restoration, they may nearly always be saved.

A PLEA FOR MORE CONSERVATISM IN THE EMPLOYMENT OF TAIT'S OPERATION FOR PELVIC DISEASE.[1]

BY W. H. SHARP, M.D.,
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OWING to the advance of abdominal surgery, and stimulated by the example of Mr. Lawson Tait, there has sprung up in this country a class of surgeons making a specialty of abdominal surgery. Many of these gentlemen have visited England, tarried at their Mecca in Birmingham, witnessed the marvellous skill of that master, and been dazzled by the celerity with which he operates and the successes following his skill, without profiting, we fear, by the rare judgment he shows in making proper diagnoses of the conditions requiring the operation.

Returning to this country impressed with the importance of these procedures, and anxious to exploit themselves before the public as experts and successful abdominal surgeons, they immediately seek for subjects on whom to exercise their skill and to show their success in curing patients by the removal of diseased organs, as well as to parade a long list of successful laparotomies. Brilliant reports of their cases are prepared and spread before the general profession, and the family physician urged to send the victims of pelvic disease to them for relief.

Some of these younger disciples of Mr. Tait are already rivalling him in the number of successful laparotomies, and every case recovering from the operation itself is heralded as a cure of long-standing and intractable disease. But somehow the reports of the cases end with their dismissal from the specialist's care when the abdominal wound is healed. We learn nothing as to the history of these cases, six months, twelve months, or twenty-four months after; nothing as to the effects upon the system, from thus abruptly changing the whole sexual life of the woman. Occasionally some of the profession more conservative offer a note of warning and protest, but it does not avail much. We are told that Mr. Tait has revolutionized the whole theory and treatment of pelvic inflammations of long standing or of recurrent nature. These gentlemen publishing the reports of such cases—first read before one or more medical societies, then published in some one of the medical journals, then put forth as a reprint and scattered broadcast over the land among the general practitioners—thereby make their cases, methods, and results public property, which should be considered, without reference to the gentlemen offering them, solely from a scientific standpoint. In the *American Journal of Obstetrics*, July, 1889, is an article of this kind, written

[1] At the time this article was written several papers on the subject by other authors, which have since appeared, had not been published.

by Dr. B. Curtis Miller, of Charleston, W. Va., entitled "A Year's Record of Seventy-five Successful Cases of Abdominal Section." In a footnote he refers to 144 cases of laparotomy—which, from the text, I judge comprised his cases in a period of from eighteen months to two years. Of the 75 cases reported, 42 were cases of salpingo-oöphorectomy, of which number 27 were for diseased or presumably diseased tubes and ovaries, and 15 for uterine fibroids. Studying this report one is struck with the extreme brevity of the reports of the cases; the meagre character of the information given as to the symptoms demanding the operation, and the absence of details upon the pathological conditions found; nothing told of the previous treatment; and still more glaring is the utter neglect to tell us anything as to the after-history of the patients. For proof of this assertion I quote the following:

"Case II. Both tubes occluded and adherent; ovaries cystic. Case V. Tubes occluded and distended by a dark fluid; no adhesions; ovaries cystic, with small amount of pus. Case XII. Ovaries removed; rapid recovery; no pain since operation."

The latter was a case of dysmenorrhœa in a patient weighing 200 pounds. General health good. No account of condition of ovaries given.

"Case XIII. Ovaries cystic; small quantity of pus observed in right one. Case XIX. Ovaries cystic and considerably enlarged. Tubes in a catarrhal condition."

This appeared to be a peculiar case in that the patient was twenty years old, had been married only nine months, and

"suffered with more or less dysmenorrhœa and leucorrhœa, with constant uneasiness over ovarian region."

Certainly, on the face of the report, it appears as if some less heroic treatment than spaying could have been offered to this patient just upon the threshold of married life with its aspirations of maternity. General practitioners everywhere have seen women so affected conceive, and fulfil the duties of the married state.

"Case XXIII. Mother of two children, a great sufferer from dysmenorrhœa. Both ovaries enlarged and very sensitive."

Could not medical treatment have offered some relief to such a sufferer, save so serious a surgical operation, no matter how skilfully done?

"Case XXVII. Both ovaries greatly enlarged, very soft and spongy."

It appears that the operation was done because of profuse menstruation. No history of prior treatment or of results. Of the fifteen cases done for uterine fibroids there is no history, no reason why the operation was necessary, nor a single word as to the resulting benefits to the patients—whether or not the enforced menopause caused arrest of development. Fibroids have not always become quiescent after the cessation of menstruation. Under "Ovariotomy," our reporter says:

"Nine cases for the purpose of extirpating diseased ovaries or for the relief of troubles arising therefrom."

What troubles we are left to guess. Of what scientific value is such a statement? Under the head of "Miscellaneous Sections" are given five cases for uterine fibroids, with not a word as to what was found or what was done, whether the fibroids were removed, or the tubes and ovaries taken away, or the uterus amputated. I forget Case XVI.:

"Patient had bilateral laceration of the cervix, suffered from various reflex nervous troubles, soreness over lower abdomen, dysmenorrhœa, and difficult locomotion."

On April 14th, he operated on the lacerated cervix; and, not waiting to see what effects were to follow Emmett's operation—effects which, we all know, require weeks, and sometimes months, to develop—or allowing the nervous system to recover slowly from the effects of reflex irritation, this physician, on May 8th, twenty-five days after operating on the cervix, removed the ovaries; one containing one ounce of serum, the other filled with blood and serum. Patient made a rapid recovery. It would appear to an uninitiated general practitioner from this report of the pathological condition that it was necessary for the operator to find something, however slight, to justify this case of spaying.

In fact, this whole report is simply the heralding of the success of the individual operator in performing abdominal section. In the same number of the *Journal of Obstetrics* before cited, is the report of the proceedings of the American Medical Association, where, in the papers read and in the discussions upon the treatment of pelvic abscesses, the same radical treatment is advocated: abdominal section urged in all cases of pelvic abscess, viz., in all collections of pus in the female pelvis; and the drainage of these by vaginal incision, or aspiration through the same canal, condemned in unsparing terms. One acquainted with the names of the gentlemen taking part in the discussion could readily recognize the fact that most of them had been pilgrims to the shrine of Birmingham. A gentleman whom I in former years had the pleasure of knowing, some years since went to Europe and passed some months with Mr. Tait, and has since been devoting himself to abdominal surgery, especially as applied to gynecology. Able, energetic and enthusiastic, he has earnestly, by voice and pen, advocated the views of Mr. Tait. In a paper read before the Cincinnati Medical Society, January 2, 1888, he advocated

"the performance of the operation at the end of from four to six months after the onset of the disease."

Later, in May, 1888, in a paper read before the Section of Obstetrics, American Medical Association, he said:

"I believe that the best plan to pursue in these cases, after a period ranging from twelve to eighteen months of constant and proper care and treatment which is not followed by more than temporary relief, is to advise an operation for the removal of the diseased structures, as the safest and best treatment; safest because a very small per cent. die if properly cared for, and best because it is a permanent cure."[1]

Certainly the later is the riper and wiser conclusion. In most of these reports the operators end their histories of the cases with their dismissal, the recovery from the operation being complete; but we are left in the dark as far as the future of the patient is concerned. Are they restored to health and able to resume the duties of their lives? Being in a neighboring town lately, I inquired of several who were in a position to know concerning the health of one of these patients thus operated upon some two or three years since. If my information is correct she is still an invalid—certainly not restored to health, even if relieved of recurrent attacks of pelvic inflammation. In this series of 75 cases of Dr. Miller, 15 are for removal of ovaries and tubes for uterine fibroids. All the comment is:

"That oöphorectomy was performed upon these patients for the premature induction of the menopause, since it *seemed to promise* [italics mine] better results and greater relief than any other method of treatment, when the numerous complications and varieties of disorders noticeable in many of them had been carefully considered."

No information is given as to why the operation was necessary, what complications were noticeable, or what relief was obtained. I know of a number of cases of uterine fibroids under the care of my medical friends, as well as my own, who, with well-considered medical treatment, are getting along fairly well and attending to their household duties. For the benefit of those of the profession who think that nothing can be offered to such patients but removal of the uterine appendages, I commend a careful perusal of the paper of Dr. Bedford Brun, of Alexandria, Va., in *Gaillard's Medical Journal*, 1887 or 1888, on the "Treatment of Uterine Fibroids," or again, to the reports made by those who have used, or seen used, Apostoli's treatment.

In the discussion of Dr. Hall's paper at the American Medical Association, 1888, Professor Goodell, than whom none is more qualified to speak, took conservative ground, saying that he did not believe that because the ovaries or tubes contained serum, blood, or pus, they should for that reason be removed; he said:

"It is more judicious to give the patient first the benefit of preliminary treatment before resorting to an operation."

And further:

"One reason which should guard us against using the knife too hastily is, life is too dear to be jeopardized by a hasty operation. A certain percentage of women will die after all operations, and, if the truth be always told, a still greater per cent. will, perhaps, be found."

He feared that too many, especially of the younger practitioners, were urged to operate "by papers read." (Above from reprint of Dr. Hall's paper.) Others have also joined in these warnings. In a late number of the *Journal of the American Medical Association* is an able editorial article, entitled "Prurigo Secandi," based upon the warnings of Professor Lefort, in his late editions of *Malgaigne's Surgery*, from which I make the following extracts. The application there is not confined to abdominal surgery. Lefort says:

"When I see the multiplication of successive operations for diseases which a hospital experience of more than forty years has shown me to be either relatively rare, or curable by non-operative treatment, I am led to believe that many of these surgeons, instead of asking themselves what operations the disease and the hopelessness of the treatment compel them to perform on the patient, inquire rather, is the patient one whom they can induce to undergo the operation just then under consideration, not to say in fashion."

The editor, commenting upon the text of Professor Lefort's remarks, further says:

"The fact that an operation is capable of curing the disease is not of itself a justification for the operation. The gravity of the operation must be compared with the gravity of the disease. The benefit to the patient must be proportioned to the danger to which he is exposed."

Certainly this applies to such an operation as the removal of the uterine appendages for dysmenorrhœa, or even a constant pain over the ovaries, or for a persistent menorrhagia. As illustrations showing that well-directed local treatment will, in many instances, so improve the condition, I cite the following histories:

Mrs. X., the mother of three children; the youngest died in infancy, twelve years previously. She had for some years suffered with painful menstruation, which required her to keep her bed for one day during every menstrual period, which recurred every third week, and was not profuse. At such times she took some anodyne, but formed no habit. I treated her for endocervicitis, without relief to the painful menstruation. She led an active life, attending to her household duties. Later she developed an attack of pelvic inflammation on the right side. This I am certain was specific, her husband being under treatment for gonorrhœa. I aspirated and drew off some pus, more escaping along the track of the needle, *per vaginam*. Under careful nursing, complete rest, hot vaginal douches, and applications of tincture of iodine, and glycerin tampons, together with tonic constitutional treat-

[1] Reports of papers read by Dr. R. B. Hall before the societies mentioned.

ment, she recovered. For several months at the menstrual period she suffered more, and during one or two had a discharge of pus *per vaginam*. She is now as well as before the attack, and leading the same active life.

The following case occurred in the practice of a friend:

Mrs. G., mother of one child, which was fifteen years old. After the birth of this child she had a bad getting-up. Patient had constant pain in the left ovarian region and was treated by several physicians of experience during the following years. Two years ago she came under the care of a physician who found the uterus enlarged, with evidence of former pelvic inflammation—endocervicitis—and a discharge from the uterus of muco-pus. Under local treatment similar to that described above she improved greatly. Being away on a visit to a sister in the city where she had formerly resided, she consulted a man of prominence, who diagnosed an ovarian tumor on the right side, the size of an orange, and advised operation for its removal. Being alarmed, on her return home I saw her in consultation. I found enlargement on the right side, not as large, however, as an orange. The uterus was still enlarged, but it was evident that she had greatly improved under the treatment; I advised its continuance. More than one year has passed; she is better, attends to her household duties, and suffers only with the old pain in the *left* ovarian region.

The following case occurred in the practice of Dr. H.:

Mrs. A., mother of one child; had some stenosis of cervical canal, possibly caused by former applications of nitrate of silver. She was also suffering from some reflex nervous troubles. This condition was treated by gradual dilatation. There developed a swelling as large as a hen's egg on one side of the uterus, with tenderness and pain. Hot applications and rest were followed by a discharge of pus *per vaginam*, judged to be from the uterus. This happened twice while under Dr. H.'s care. The patient said it had happened twice before; the last time while she was under the care of a distinguished gynecologist of one of the Western cities, who had advised removal of the ovary. Under Dr. H.'s care she recovered and for over a year has been perfectly well.

I could cite other cases who were made comfortable, though affected by pelvic troubles, with pain and tenderness as a prominent feature, without recourse to an operation. Patients not robust, it is true, and at times suffering from pain, but able to enjoy life and contribute to the happiness of those around them. Could an operation for the removal of the uterine appendages do more for these patients? I do not wish to deny that this operation is often necessary; but to protest against this tendency on the part of those calling themselves abdominal surgeons, to offer this operation to women who suffer from pelvic pain and pelvic inflammation as the only cure for their troubles. Twenty-five years ago, when I entered the profession, Marion Sims had offered incision or discission of the os uteri as a cure for dysmenorrhœa and sterility. Allured by his captivating writings and brilliant successes, throughout the country enthusiastic followers were cutting the cervix, with results disastrous, or at least disappointing, to their patients. Later, stimulated by the teachings of Emmet, without the restraining influence of his mature judgment, a host of imitators arose who deemed it necessary to excise every bit of cicatricial tissue *and more too*, which accompanied every *slight* tear of the cervix—giving almost just ground for the *bon mot* of the Englishmen—"that Americans slit the cervix to sew it up again." And now another generation appears who are out-Heroding Herod in their anxiety to perform laparotomy in all cases where the patient can be persuaded to part with her ovaries. As further support to what I have written, let the reader refer to a late paper read by Dr. J. M. Baldy before the Philadelphia Obstetrical Society, March 7, 1889, entitled "Complications following Abdominal Section." Dr. Baldy is an experienced operator and knows whereof he writes. He shows the dark side, details the various complications following recovery from laparotomy, which are little, if any, less burdensome to the patient than the original disease. He, in conclusion, says: "When any person about to undergo an abdominal operation must run the gauntlet of all these complications, as well as many more, it becomes a serious matter in deciding for or against an operation. We have here more than the immediate risks to life to consider. We must think —Has his or her present disease been removed, will they be any better off, or may they not be the worse for the interference? At any rate, such a state of affairs should be a warning to inexperienced men not to be misled by brilliant reports seen in the journals, and not to rush thoughtlessly into an operation expecting to produce the same results. They should know that as a rule only favorable cases are reported, and that men do not like to publish to the world their bad work or misfortunes. Abdominal surgery is by no means the easy and simple procedure some men would make us believe, and such an operation should never be undertaken except after careful consideration of all the risks that must be run, the chances of benefit to the patient, and in the presence of actual demonstrable disease. Until the dark sides of abdominal work are well known to the profession at large, the *furor operandi*, which has been so justly complained of, will continue, and many women will succumb to the results of inexperience." And we might justly add, to the results of

inexperience, operating where there is a lack of judgment in the selection of proper cases, or where there is present an overweening desire to perform a brilliant operation—where success will give so much more *éclat* than the same or better results following the slower and safer medical treatment.

NOTE.—After writing the above, looking over some journals of the past year, I found the fullest confirmation of the foregoing argument in several papers to which I must briefly allude. First, to the reports of the discussion on "Nervous Symptoms Arising from Ovarian Disease, and their Treatment" in the Section on Neurology, New York Academy of Medicine, *Medical Record*, June 22, 1889, by prominent neurologists and gynecologists. The question of the removal of ovaries and tubes for neurosis was fully discussed, and the consensus of opinion was very conservative, if not condemnatory. In this discussion, Dr. Field stated that he knew of thirty or forty cases of insanity following the removal of ovaries in patients at the Blackwell Island Asylum. Also, mention may be made of the paper by Professor T. Gaillard Thomas, on "Insanity following Gynecological Operations (see THE MEDICAL NEWS, April 15, 1889), and a report of two cases of insanity following Tait's operation in THE MEDICAL NEWS, November 16, 1889. All these articles, and many similar which may be found in current medical literature, tend to show that Tait's or Battey's operations are not to be lightly or enthusiastically offered to patients as a sure relief to their troubles, for flying from the evils which they know may lead them to a far worse fate.

THE CLINICAL ASPECTS OF THE PRESENT INFLUENZA EPIDEMIC IN WOMEN AND CHILDREN.

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THE prevaling influenza became epidemic in Philadelphia first among the nurses of the Philadelphia Hospital, where the writers had the opportunity of observing its characteristics. The nurses attacked were women, most of them younger than thirty years, in as good general health as the duties of nurses in a large general hospital permit. That it was not an epidemic of nervous deception caused by fear of the affection was demonstrated by the fact that the first cases were not recognized at once as being influenza, and that many of those affected were women especially stolid regarding illness; they were furthermore very desirous to keep on duty and rarely reported themselves as ill until obliged to do so.

Regarding the beginning of the epidemic, the first case was that of an English immigrant who came to the hospital three days after landing at Castle Garden. He had been exposed to cold and wet, and presented symptoms of a severe cold which was followed by pneumonia, from which he recovered in two weeks. Occupying a bed next to him was a patient who was able to serve as waiter in the nurses' dining-room. He had influenza shortly after the immigrant's arrival, and following his attack the nurses were seized by the disease before it became epidemic in the Hospital.

The affection itself had in many cases a prodromal stage of general malaise; others missed this preliminary prostration and were suddenly taken ill. Pain in the cranium, back and muscles usually forced the patient to succumb. This was accompanied by a chill and an elevation of temperature in many cases reaching 104° F., the pulse rarely exceeding 100, the respiration remaining but little accelerated. In uncomplicated cases gradual defervescence succeeded, occupying seventy-two hours on the average; the lowest temperature reached was 96°, usually 97° was the limit. The return to a nearly normal temperature was marked by bronchial catarrh, transient slight pulmonary œdema; nasal and intestinal catarrh in some, intestinal and facial neuralgia, and by a degree of nervous prostration greatly disproportionate with the gravity and duration of the other symptoms. A mild grade of tonsillitis and pharyngitis, and occasionally conjunctivitis, followed the attack. Persistent anorexia, muscular and nervous weakness, characterized the convalescence of most patients; in a few the appetite remained unimpaired through the illness. The average duration of uncomplicated cases was from four to seven days. The percentage of complicated cases in the series studied, numbering forty cases, was 12.5 per cent.; the percentage of relapses was 2.1 per cent.

A noticeable feature of the epidemic has been the absence of nasal catarrh in many cases, while bronchial catarrh has been especially well marked. The complications observed have been severe follicular tonsillitis, catarrhal, lobular pneumonia, and an accentuated first sound of the heart, with evidences of a beginning mitral obstructive lesion in one case. These complications have not assumed a severe type; one case of catarrhal pneumonia is persistent, and gives rise to a suspicion of tubercular infection. In a case which had a second attack, it is curious to note that catarrh, nasal and bronchial, was present in the first but not in the second attack; the latter was characterized by severe headache and muscular and neuralgic pain. In many cases menstruation was precipitated by the illness.

In general, the epidemic among the nurses bore the characteristics of an infection of varying severity, the effect of the infective agent upon the nervous system resembling somewhat that produced by diphtheria. Defervescence in these cases was followed by prostration disproportionate to the degree of fever; the special senses occasionally suffered, the abolition of taste being especially frequent. Severe conjunctivitis occasionally followed an apparent convalescence. Loss of weight generally occurred, to the extent of one-twentieth or one-twenty-fifth of the body weight. The secretions and excretions were those of any similar fever; commencing defervescence was frequently ushered in by profuse perspiration. Regarding treatment, antipyrin, antifebrin, and phenacetin were used to relieve the pain and fever of the first stage, the best results being obtained by antipyrin in five-grain doses. So soon as the fever declined, quinine, iron, and strychnine were persistently given, with easily digested food (milk and soups) and occasionally red wine. The mouth was rinsed and the throat gargled with equal parts of a saturated solution of potassium chlorate and boric acid, with glycerin. Symptomatic treatment was added to this routine as needed. In the bronchitis which so frequently followed the febrile stage the best results were obtained by ammonium chloride given in plain soda water, without syrups. Among the nurses the tediousness of convalescence was very marked, persistent tonic medication being required for ten days or two weeks after hospital work was resumed.

In addition to this epidemic among hospital nurses, other cases in women present points of interest. In a woman aged sixty-eight, vesical irritability with great prostration were the first symptoms observed. Continued fever (101° and 102° F.) followed for four days; convalescence has been very slow, with no nasal and but little bronchial catarrh, diagnosis in this case being based upon symptoms of a constitutional infection. Influenza does not seriously complica' normal abor or the puerperal state. In a recent uncomplicated labor no elevation of temperature or complication, except bronchial catarrh, followed delivery, although the mother suffered from influenza. Her child, on the fourth day, manifests no symptom.

That influenza may give rise to serious pneumonia in the puerperal state is exemplified by the case of a primipara. Suffering before labor from nephritis, asthma, and hydramnios, with contracted pelvis, delivery was difficult, the position being occipito-posterior and necessitating the forceps. Chloroform was used preferably to ether and delivery was safely accomplished. Severe bronchitis, with constant tendency to catarrhal pneumonia, supervened, from which the patient is making a difficult recovery. An example of the gravity of influenza when added to an impaired condition of the heart is shown by a young woman, apparently in good health, who visited my office recently for advice concerning a beginning bronchitis of influenza. While narrating her symptons angina pectoris suddenly developed, and for several hours her condition was one of great suffering and considerable danger. A peculiar harsh, brassy cough followed the pain and dyspnœa, and as respiration and cardiac action became better she was taken to her home in a carriage. She, too, presented unmistakable symptoms of a severe infection. In young children influenza may run its typical course, speedy convalescence following. Such has been the history of the majority of cases in carefully nursed infants in the Philadelphia Hospital, simple remedies sufficing to relieve symptoms. Occasionally a severe broncho-pneumonia results, as in a recent fatal case in which persistent high temperature (104°, 105°, and 106° F.) resisted all efforts at reduction. The child nursed eagerly, remained conscious, but was constantly pallid and asphyxiated. The persistence of the fever in this case was very noticeable. In older children pneumonia often follows influenza and proves unusually prolonged and intractable. A recent case of pulmonary tuberculosis in a boy aged eight years was complicated by influenza.

Severe bronchitis and broncho-pneumonia in those portions of the lungs not apparently infected by tubercle followed influenza, and severe illness resulted, from which recovery was slow. In cases in children who are not enjoying the benefits of the constant care of trained hospital nurses, the following formulæ have been found of value, and may be entrusted to even ignorant mothers:

For simple bronchitis of larger bronchi, with headache, fever, and restlessness:

℞.—Acid. hydrobromic. dil. . . ♏ 10.
Syrup. scillæ . . . . ♏ 10.
Aquæ . . . . ad ℥ 1.—M.

Every two hours, if required.

For capillary bronchitis with threatened suffocation, Henoch's powder is useful:

℞.—Camphor pulv. . . . gr. ¼ to 1.
Acid. benzoic. . . . gr. ¼ to 1.
Sacch. alb. . . . gr. 7½ to 10.—M.

In ten powders. One powder every two hours.

To this should be added the free use of whiskey and ammonia, a cotton or oiled silk jacket worn over the chest, and inunctions with camphorated oil; in severe cases croton oil diluted with olive oil may be applied over the sternum once or twice.

In conclusion, it may be remarked that, while evidence of distinct contagion is lacking, the coincidence shown in the arrival of the immigrant and the development of the epidemic at the Philadelphia

Hospital is interesting. As has been observed by others, evidences of infection, varying in degree and in organs whose functions were deranged, but affecting chiefly the nervous system, were constantly and unmistakably present.

MEDICAL PROGRESS.

Treatment of Buboes by Iodoform Vaseline.—The following is Professor Pontain's "rapid method" of curing buboes: 1. Washing and disinfection of the region by means of hot sublimate solution (1 : 2000). 2. Puncture with the lancet if the skin is soft; with the straight bistoury if the pus is deeply situated. The puncture is small and made in the most fluctuating point. 3. Evacuation of the pus, gently pressing out completely the contents of the ganglion. A few injections of sublimate solution are now made to wash out the cavity. 4. Injection of iodoformized vaseline melted by heat. The oil is to be gently injected in by means of a glass syringe previously charged and placed in hot water. 5. Dressing with absorbent cotton. As soon as the cavity is full of the iodoformized vaseline, a wad of cotton, soaked in sublimate solution 1 : 1000, is placed over the bubo, and kept in place with a spica. The contact of the cold congeals the vaseline, and makes a plug at the orifice of the abscess. After the first day all pain disappears, and, usually, healing is complete in six or seven days. In some cases it is necessary to renew the injections of vaseline. Out of forty-one buboes thus treated by the author, more than half were cured in less than five days. The most rebellious required twenty-three days.—*Journal of Cutaneous and Genito-urinary Diseases*, December, 1889.

Creolin in Gynecology.—Extensive experiments have been made by CHÉRON with creolin in two and five per cent. solutions. The weaker solution was used for vesical injections in cases of gonorrhœa. Neither poisoning nor pain resulted; the discharge from the urethra diminished and soon disappeared, injections being made every other day. Gonorrhœal vaginitis was quickly improved by irrigation of the vagina and vulva with the five per cent. solution. In purulent cervical endometritis the diseased tissues were first carefully cleansed with absorbent cotton, after which an application of the five per cent. solution was made. After a few applications the suppuration ceased. Creolin gauze was found to be an excellent substitute for iodoform gauze in cases of suppurative and hemorrhagic endometritis in which a tampon was required. From the foregoing it was concluded that creolin has a very positive effect upon the microbes of gonorrhœa and of pus, and that in ordinary doses it is neither painful nor toxic.—*Annals of Gynecology*, December, 1889.

Effects of Chloralamid and Somnal.—One of the most careful clinical studies of the two new hypnotics, chloralamid and somnal, yet reported has been made by Dr. ADOLPH ROBINSON, of Berlin (*Deutsche medicinische Wochenschrift*, December 5, 1889), who, after numerous observations upon fifty patients suffering from many diseases, concludes that:

1. Chloralamid frequently causes a weak pulse; somnal, even in the same patients, has no noticeable effect upon the circulation.

2. The hypnotic effects of the drugs are about equal, neither producing a sound sleep.

3. Vomiting within an hour after the ingestion of either drug is not uncommon and is sometimes violent. In the cases where vomiting is not produced, loss of appetite, nausea, gastric pain, giddiness and headache on the following day are frequent. These effects are more frequent after the ingestion of somnal than after chloralamid.

Quinine in the Treatment of Syphilis.—A writer in the *Vratch*, November 21, 1889, recommends quinine in the treatment of syphilitic patients in whom cachexia and fever are marked symptoms. The quinine should be administered in doses of from fifteen to twenty grains daily, associated with mercurial inunctions. The drug prevents ptyalism and stomatitis, and, if ulcers are present, hastens their cicatrization. Quinine is useless in ordinary cases of syphilis.—*Bulletin général de Thérapeutique*, October 13, 1889.

Weil's Disease.—DR. WEISS, of Prague, who has made a careful study of Weil's disease, classifies and describes the symptoms thus:

1. The febrile symptoms are marked at the beginning of the disease, the fever being characterized by morning remissions. Between the fifth and seventh day the temperature begins to fall, reaching normal about the tenth or twelfth day. In some cases, after a period of normal temperature, there is a second accession of fever, seldom, however, a true relapse.

2. Pain in the limbs is a distressing symptom, rendering pressure or motion unbearable to the patient.

3. Gastro-intestinal symptoms are seldom distinct.

4. Jaundice is the most characteristic symptom, and is in all cases icterus from obstruction. Associated with the jaundice is swelling of the liver, the size of which depends upon the amount of biliary retention.

5. The swelling of the spleen, which is acknowledged by all authors, appears early and is a strong point in favor of the infectious nature of the disease.

6. Nephritic symptoms, such as hemorrhagic nephritis, are common and often very serious.

Bronchitis, epistaxis, herpes, purpura, petechia, and erythema, as accidental complications, have all been observed. The statistics of the epidemics in Prague show that men between the ages of twenty and thirty-five years are most frequently affected, and women and children less frequently.

The greater number of cases are seen in the summer months, but sporadic cases develop at any season. Epidemics of the disease are unquestionably caused by bad sanitation. It is infectious, but its contagiousness is as yet undecided.—*Wiener medizinische Presse*, November 17, 1889.

Naphthol-camphor as a Surgical Dressing.— DR. SCHWARTZ has been using for a year, and with very satisfactory results, naphthol-camphor as a surgical

dressing. The naphthol-camphor is prepared by mixing one part of beta-naphthol with two of camphor, the combination making a brownish transparent fluid which readily saturates dressings. Schwartz has used this fluid as an application in cases of tubercular ulceration, cold abscesses, and suppurative otitis media. Ulcers, he states, should be dressed with gauze soaked in the solution, covered with protective and the whole with cotton wadding. This should be changed every day or two. Immediately after the application the patient feels a slight burning, which, however, soon disappears. According to Schwartz, the naphthol-camphor causes a luxuriant growth of healthy granulations, and cicatrization progresses at least as well as with iodoform dressings. Large quantities may be applied without danger of toxic symptoms. Occasionally a slight erythema appears upon the surrounding skin, which can be avoided by the use of borated vaseline. For suppurative otitis the ear should be syringed with a warm boric acid solution, after which the naphthol-camphor is dropped into the ear and the meatus closed with a cotton pledget. Discharge, offensive odor, and pain quickly disappear.—*Wiener medizinische Presse*, December 1, 1889.

Intra-laryngeal Injections of Menthol in Phthisis.—MR. WALKER DOWNIE, in the *Glasgow Medical Journal*, December, 1889, reports excellent results in the treatment of tubercular laryngitis and early phthisis with the intra-laryngeal injections of solutions of menthol in olive oil. To the solution he usually adds pure creasote in the following proportions:

Creasote	2 parts.
Menthol	12 "
Olive oil	86 "

An ordinary hypodermic syringe with a detachable vulcanite laryngeal tube is the most satisfactory apparatus. In administering the injection a laryngeal mirror should be used, by means of which the curved nozzle can be guided into the larynx without coming in contact with the tongue or fauces, thus obviating all risk of retching. The point of the syringe should be just below the vocal cords when the fluid is injected. If the fluid is applied to the cords, it produces a choking sensation, often with spasmodic cough. From twenty to thirty minims should be injected at intervals of a few minutes until a drachm and a half has been used. The patient's immediate sensations are a comfortable warmth throughout the chest, loss of inclination to cough, and disappearance of "tightness" of the chest, if it existed. Cough is often absolutely checked for from four to eight hours. Expectoration is reduced in amount and purulency. The majority of patients gain in weight, and high temperature is often permanently reduced during treatment.

The probable explanation of these effects is that the menthol acts as a local anæsthetic to the mucous membrane of the larynx and bronchi; that it is a powerful, though harmless, stimulant; and that it is an antiseptic which, being very volatile, is rapidly diffused throughout the lung.

Resorcin in the Treatment of Whooping-cough.—DR. CONCETTI, in the *Wiener medizinische Blätter*, asserts his belief that resorcin administered internally is preferable to any other remedy in the treatment of whooping-cough. He has employed the drug in forty-eight cases—among them an infant of twenty days of age. The daily dose varied according to the age, ordinarily 7½ to 22 grains, dissolved in a considerable quantity of water, being given. The doses were given from one to two hours apart, according to the intensity of the case. In thirty-four cases the affection occurred in its typical form, with repeated spasms of coughing, accompanied by the characteristic whoop. In twelve of these treatment was commenced in the catarrhal stage before the characteristic sound appeared. The whoop subsequently appeared, but only for a few days (from six to fifteen); it was by no means severe, and the attacks occurred but seldom. In the other twenty-two cases treatment commenced in the second stage, which, in some cases, had already lasted a week or more. In these latter cases the action of resorcin was most evident, since the attacks rapidly diminished both in intensity and frequency, while other methods of treatment which had hitherto been employed in the same cases remained absolutely without effect. The author likewise states that the duration of the disease was positively shortened, some cases lasting but one week, others two, or more seldom, three weeks; in the latter cases leaving a light catarrh, which readily yielded to ordinary remedies. Dr. Concetti suggests that perhaps the results obtained by Moncorvo and others from the local application of resorcin in whooping-cough are to be attributed to the amount of the drug which had been swallowed.—*Therapeutic Gazette*, December, 1889.

Treatment of Infantile Diarrhœa.—In a paper on the fermentative diarrhœas in infants, read before the Harveian Society, DR. LUFF, while admitting that though probably several irritating substances resulting from the fermentation of milk are factors in the production of the form of acute infantile diarrhœa under consideration, contended that the principal cause was the milk or cheese ptomaine, tyrotoxicon, produced during the fermentation of milk under certain conditions. The treatment of acute infantile diarrhœa with the view of arresting the abdominal intestinal fermentation was then considered. Carbolic acid, creasote, resorcin, salicylic acid, salicylate of soda, naphthol, and salol have been given in the hope of checking the putrefactive changes in the bowels. Ringer has recommended the administration of a weak solution of bichloride of mercury in infantile diarrhœa attended with very slimy stools. Dr. Luff then referred to Illingworth's antiseptic treatment of infantile diarrhœa, which he had himself found most useful, and the employment of which had first directed his attention to the treatment he now employed. This treatment consists in the administration of $\frac{1}{10}$ of a grain doses of the biniodide of mercury dissolved in iodide of potassium, combined with one-grain doses of chloral hydrate. It was shown experimentally that the soluble biniodide of mercury is an extremely soluble and diffusible salt, and that it possesses the property of combining with and rendering insoluble the milk ptomaine, tyrotoxicon. He has never found that the soluble biniodide of mercury itself acts as an intestinal irritant. Of eighty cases of acute infantile diarrhœa treated by this method, the diarrhœa ceased within two days in seventy-two of the cases; in five of the remaining eight cases it ceased within four days, and in no case did it last over seven days.—*Lancet*, December 21, 1889.

Influence of Massage on the Secretion of Urine.—POLOUBINSKI has recently studied the influence of massage on diuresis, and his results, which indicate that massage of the abdominal region increases the urinary secretion, are published in the *Bulletin Général de Thérapeutique*, October 15, 1889. Experiments were made upon ten individuals whose renal organs were perfectly normal. During the entire duration of these experiments the diet of these persons was precisely the same in all cases. The abdomen was subjected to massage daily, the duration of each *séance* being about half an hour. The author believes massage not only increases the quantity of urine, but also the solids, urea, and especially the nitrogen eliminated in the urine. Massage of the lumbar region had no influence whatever upon the urinary secretion.—*Therapeutic Gazette*, December, 1889.

Insufflation of Salt in the Treatment of Neuralgia.—At a recent meeting of the Edinburgh Medico-Chirurgical Society, DR. GEORGE LESLIE gave the details of thirty or forty cases of facial and other neuralgias, cephalalgia, odontalgia, etc., which had been cured, in most instances instantaneously, by insufflation of powdered common salt through the anterior nares. The salt was either "snuffed" or blown up the nostrils. He had been unsuccessful in only two cases; both of these were cases of old standing, which had been treated frequently by morphine injections. In one of them excision of the nerve had been practised.—*British Medical Journal*, December 14, 1889.

Treatment of Baldness.—The following is LASSAR'S treatment for baldness:

First. A strong tar soap is applied to the scalp for at least ten minutes.

Second. Removal of the soap by a tepid water douche, the water to be gradually cooled, and the scalp well dried.

Third. The scalp is shampooed with the following mixture:

℞.—Bichloride of mercury	. .	10 grains.
Glycerin, Alcohol	. .	of each 2 ounces.
Water	. . . . .	5 ounces.

Fourth. Shampoo with absolute alcohol, to which one-half per cent. of naphthol has been added.

Fifth. The following solution is well rubbed into the skin:

℞.—Salicylic acid	. . . .	30 grains.
Tincture of benzoin	. .	1 drachm.
Neat's-foot oil	. . .	3 ounces.

—*Provincial Medical Journal*, December 2, 1889.

Salol in Gonorrhœa.—DR. DREYFOUS, of Paris, advocates the treatment of gonorrhœa with large doses of salol. Dr. Dreyfous has tested the effect of salol administered alone, and in other instances he has given it simultaneously with copaiba and cubebs in order to hasten the cure. He recommends the use of salol to surgeons who operate on the urinary organs; it renders urine aseptic, which is thus innocuous when in contact with raw surfaces.—*British Medical Journal*, December 7, 1889.

Auscultatory Percussion.—KARL CZOBOS (Gyógyászat No. 42) describes a method of auscultatory percussion which he considers of especial value in the diagnosis of disease of the pulmonary apices. It is practised by placing the ear posteriorly between the scapulæ and percussing with two fingers on the anterior surface of the chest, beginning at the clavicle and percussing each side alternately. No pleximeter is used. The sound heard in this manner is entirely different from that heard in the usual manner of percussing, the pitch changing as the alveoli are filled and emptied during respiration. Over a healthy lung the tone is peculiarly resonant, of a metallic quality, and more intense in inspiration than in expiration. If infiltration is present, the sound has a singular dull quality as of solid metal striking a hard body. An unusual amount of fat over the clavicle does not change the tone, and in patients without much fat the method can be used over the entire chest.—*Prager medicinische Wochenschrift*, November 27, 1889.

The Effects of Phenacetin.—DR. K. C. BOSE, in a paper read before the Calcutta Medical Society, summarizes the advantage of phenacetin over other antipyretics thus:

1. It causes a gradual reduction of temperature, and the rise after the effect passes off is also gradual.
2. In ordinary doses, it never causes alarming symptoms.
3. It is tasteless, and for that reason easily given to children.
4. A full dose to a delirious person usually produces a quiet night.
5. It does not cause much sweating.
6. No effect is produced by the drug upon the heart.
7. No gastric disturbances are caused by it.—*Indian Medical Gazette*, September, 1889.

Administration of Chloral in Infantile Convulsions.—WIDERHOFER, of Vienna, recommends the following, as a sedative in infantile convulsions:

Hydrate of chloral	. .	1 drachm.
Distilled water	. .	3 fluidounces.
Syrup of bitter orange peel	.	1 fluidounce.

A teaspoonful every two hours.—*Revue Générale de Clinique et de Thérapeutique.*

Sleeping Draught.—YVON uses, for adults, a sleeping draught made as follows:

Hydrate of chloral	. .	1 drachm.
Bromide of sodium	. .	1 "
Syrup of codeine	. .	5 drachms.
Syrup lauro cerasi	. .	5 "
Water	. . . .	4 ounces.

—*Revue Générale de Clinique et de Thérapeutique.*

Prescription for Asthma.—

Hydrate of chloral	. .	30 grains.
Iodide of sodium	. .	22 "
Simple syrup	. . .	4 ounces.

In an attack give a tablespoonful every hour.—*Revue Générale de Clinique et de Thérapeutique.*

Injection for Infantile Convulsions.—

Musk	3 grains.
Hydrate of chloral	10 "
Camphor	15 "
Water	5 ounces.

—*Rev. Gén. de Clinique et de Thérapeutique.*

Suppositories of Chloral.—YVON, recognizing the irritation apt to be set up by chloral when given by the rectum, recommends the following:

Hydrate of chloral	7 grains.
Extract of belladonna	3 "
Cacao butter	45 "

—*Revue de Clinique et de Thérapeutique.*

Sweating of the Feet.—LEGOUX, writing to the *Revue de Clinique et de Thérapeutique*, recommends the following for sweating of the feet:

Liquid perchloride of iron	1 ounce.
Glycerin	3 drachms.
Essence of bergamot	6 "

This is painted over the feet and between the toes. The feeling of heat and soreness is removed at once, and comfort is soon obtained for long marches.

Two Cases of Intestinal Obstruction Cured by Injections of Sulphuric Ether.—CLAUSI, in *Il Morgagni* for September, 1889, reports the cure of two cases of obstinate obstruction by the injection of 3 drachms of ether and alcohol in 10 ounces of water by means of an ordinary syringe. The patients felt a sensation of warmth in the entire belly, and immediately belched up air loaded with the odor of ether. A movement of the bowels soon afterward followed.

Creasote in Phthisis.—GILBERT recommends, in the *Revue de Thérapeutique Médico-Chirurgicale*, the following prescription for phthisis:

Creasote	½ drachm.
Rum	1 "
Syrup of tolu	½ "
Water	6 drachms.

A tablespoonful in a wineglass of water.

Or,

Creasote	½ drachm.
Arsenite of soda	½ grain.
Huxham's tincture	8 ounces.
Malaga wine	8 "

A wineglassful with the meals.

Treatment of Diphtheria and Croup.—According to the *Journal de Médecine de Paris*, GALLOIS recommends the following solution for application to the areas of mucous membrane involved:

Crystals of thymic acid	15 grains.
Essence of thyme	1 drop.
Alcohol	1 ounce.
Dissolve, and add of water	2 pints.

For application to the nasal cavities, this must be modified as follows:

Acid. thymic.	7 grains.
Alcohol	½ ounce.
Sea salt	1½ drachm.
Water	1 quart.

This should be applied about every three hours.

Lotion for Pruritus Vulvæ.—

Carbolic acid	15 grains.
Tincture of opium	4 drachms.
Dilute hydrocyanic acid	2 "
Glycerin	4 "
Distilled water	4 ounces.

Mix and apply as a lotion, or the following may be used:

Hydrochlorate of cocaine	7 grains.
Lanolin	1 ounce.

Make into an ointment, and apply a small quantity of the ointment to the area involved.—*Gazette de Gynécologie.*

Powder for Coryza.—The following prescription for coryza is quoted in the *Journal de Médecine de Paris*:

Naphthalin, finely pulverized Boric acid	āā 25 parts.
Pulverized camphor	1 part.

To which may be added one or two minims of essence of rose. A pinch is to be occasionally snuffed into the nostrils.

Operation for Prolapse of the Rectum.—M. VERNEUIL, at the Société de Chirurgie, described a new method of treating rectal prolapsus, by attaching the adhesions of the posterior surface of the rectum to the corresponding portion of the pelvis. After reducing the intestine, the portion of the anal orifice to be excised is determined. A triangular fragment is then traced by means of two transverse incisions passing through the posterior portion of the anal orifice, and two others passing from the extremities of the two first to the point of the coccyx. When the rectum is exposed, four horsehair sutures are introduced into its wall and placed at intervals of about half an inch from each other. The intestine is raised by drawing all the threads toward the concave portion of the sacrum. In order to fix the intestine permanently, the threads are drawn through the skin to the right and left of the wound, one and three-quarters inches distant from the median line, with Emmet's needle. Thus four handles in the form of a U are contrived, which may be tightened at will. The fragment traced as above described is then detached at the base. The ano-coccygeal wound is closed by transverse sutures. A large drain is placed at the back of the rectum, in order to form a track which will sustain and increase the adhesions. The anal orifice is contracted by horsehair suture. M. Verneuil obtained good results in a case which had lasted four months with this method, which he names "posterior rectopexia." At the same meeting M. Delens recommended the following method in cases of voluminous prolapsus. He applies fuming nitric acid to the tumor, reduces and plugs the anus, and administers opium in order to prevent the occurrence of stools during at least eight days. M. Schwartz has obtained good results by making scores with the thermo-cautery on the projecting intestine, and pushing backward the anus toward the coccyx, the old orifice being closed by perineorrhaphy. M. Segond considers that ablation should be practised in order to perform colopexia with success. —*British Medical Journal*, December 21, 1889.

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SATURDAY, JANUARY 11, 1890.

"MENTAL HEMIANOPIA."

IT is with much regret that we note the practical failure of the work of the commission appointed by the New York Neurological Society in March, 1887, to investigate the claims of Dr. George T. Stevens that "difficulties attending the functions of accommodating and adjusting the eyes in the act of vision, or irritations arising from the nerves involved in these processes, are among the most prolific causes of nervous disturbances, and, more frequently than other conditions, constitute a neuropathic tendency." The November number of *The Journal of Nervous and Mental Diseases* is devoted to its report, with some preliminary notes, and we give elsewhere a summary of the report of Dr. Stevens's protests, and the discussion at the meeting of the Neurological Society, on Nov. 5, 1889, when these were presented. The inquiry grew out of a paper read by Dr. Stevens on "Irritation arising from the visual apparatus considered as elements in the genesis of neuroses," in which extreme claims were made as to the importance of ocular strains and the great benefit of their correction for the relief of insanity, epilepsy, chorea, and other nervous disorders; and a commission consisting of Drs. Seguin, Birdsall, Starr, W. O. Moore, D. Webster, C. L. Dana, and F. P. Forster, was appointed to investigate the matter, by submitting cases of such disorders to Dr. Stevens for treatment, and studying the results.

It was to be anticipated that difficulties would arise in the investigation, and that the result reached would not obtain unanimous acceptance either for its facts or its deductions; the personal equation forms so large a factor in judgments as to functional nervous troubles that the most competent and honest observers might well differ as to the first and last states of the patients studied; and the statements of such patients about themselves, which would form not a little of the evidence, must of necessity possess but limited value. Still, it was not unreasonable to expect a report made in judicial spirit, and set forth with sufficient accuracy to secure respectful attention.

Such a hope is hardly realized; and the phrase of our heading, which Dr. Stevens uses to characterize the views of the commission, must appear to have some justification even to those not at all inclined to take his part in other respects. The unfavorable report gives evidences of serious inaccuracies, and the inclusion of the series of cases admittedly "not counted," savors strongly of bias and injustice. During the two and a half years the commission furnished but twenty-eight cases—five choreic and the rest epileptic—and only one-half of these were available for the study; and this poverty of material, coupled with the withdrawal of at least one suitable case, goes to show, as he claims, that ordinary, typical cases were withheld in order to increase the difficulty of his task. In the Neurological Society, the small assemblage which met to hear the report, and accepted it by a vote of five to four, is another of the unfortunate aspects of the affair, which detracts greatly from the weight of the judgment which has been passed against Dr. Stevens's claims. That these claims were apparently extravagant, and advocated by Dr. Stevens and his followers with more zeal than discretion, should have had little influence with this commission, which offered to put them to a judicial test; and the room for cavil which the report affords will rob it of much of its weight with the unprejudiced, while it awakens some sympathy with Dr. Stevens as having met with scant justice.

The real result of the whole matter is not very difficult to discover, however. The terms upon which Dr. Stevens was willing to undertake the test indicates a standpoint much less advanced than that which underlies some of his utterances; and there is unanimity in the opinion of some of the members of

the commission—those who on entering it inclined to favor his views having no word of dissent from the condemnatory opinion of those whom he looked on from the start as his antagonists. The President of the Society in 1887, who, acting in Dr. Stevens's interest, was largely instrumental in setting the inquiry on foot, who was added to the commission as Dr. Stevens's choice, and who furnished nearly one-half of the cases studied, stated in the discussion that he had lost most of his faith, as he had seen no case much improved under Dr. Stevens's treatment.

To a looker-on there is not a little rather amusing in the controversy, as the matter may be termed. Dr. Stevens would seem to have been the first to call the attention of many of his fellow-townsmen to the fact that there are ocular muscles, and that these are not infrequently out of perfect order. His "discovery" and "the Stevens method" are quoted with awe by many who do not count themselves his disciples; and the zealous advocacy in word and deed of "graduated tenotomy," "the Stevens operation," by his followers has made "muscle-nicking" a town topic in lay circles. Patients as well as medical men have been infected by Dr. Stevens's enthusiastic confidence in his views, as evinced by their submission to series of operations sometimes numbering a dozen or more; and he has, at least, succeeded in awakening in some ophthalmologists a better appreciation of a neglected subject than would probably have resulted from decades of less sensational advocacy.

THE TREATMENT OF SNAKE-POISONING.

WHILE it is perfectly true that snake-poisoning is a fortunately rare occurrence in this part of the country, it is equally a fact that in the western portions of the United States persons suffer quite frequently from accidents of this character, and it is, therefore, of importance that some knowledge of the proper treatment of such cases should be sought after. Among the laity, particularly of the less educated classes, the survival of an animal or man who has been bitten by a snake after the administration of the simplest form of remedy is an argument of such *post hoc propter hoc* force, that the witnesses are forever willing to stake their reputations as to veracity on the efficacy of the measure or drug, and to act as missionaries in the promulgation of its valuable powers among their fellows. As a result of this, a very large number of so-called remedies are to be met in every region where poisonous snakes abound.

The well-known studies of Weir Mitchell, carried on during many years, culminating finally in the joint paper written with Reichert, reached three conclusions which are worthy of note in this connection; namely, that, as the poisons act directly upon the blood, disorganizing it, the fatality of the case must depend largely upon the quantity of the poison introduced into the blood, be the antidote what it may; that the secret of successful treatment lies in the antagonizing of the poison in the wound before the toxic agents gain entrance to the blood, and, above all, that the substance to be used for this purpose is permanganate of potash. It is unnecessary to add that stimulants, external heat, and other means dictated by common sense are to be employed.

We have called attention to this matter because in another column will be found a letter from Dr. Mitchell, which is self-explanatory, and one from an army officer who has had a wide practical experience concerning the matter under consideration.

SOCIETY PROCEEDINGS.

NEW YORK NEUROLOGICAL SOCIETY.

Meetings of November 5 and December 3, 1889.

THE PRESIDENT, GEORGE W. JACOBY, M.D., IN THE CHAIR.

In March, 1887, a commission consisting of Dr. E. C. Seguin, Chairman, Dr. M. A. Starr, Secretary, and Dr. W. R. Birdsall, together with two ophthalmologists, Drs. W. O. Moore and David Webster, and two other gentlemen nominated by Dr. Stevens, viz., Drs. C. L. Dana and Frank P. Foster, was appointed by the Society to investigate, in conjunction with Dr. G. T. Stevens, the treatment of ocular irritations as a therapeutic measure in certain neuroses. This commission presented its report on the

TREATMENT OF EPILEPSY AND CHOREA BY THE CORRECTION OF OCULAR DEFECTS

in November, the discussion being concluded at the December meeting. Immediately preceding the reading of the report the following protest was presented by Dr. G. T. Stevens:

"Mr. President and Gentlemen of the Neurological Society: I respectfully protest against the reception of the report now announced, for these reasons: 1. That the commission having failed to perform its part of the agreement upon which the report is to be founded, the report is not now in good order; 2. Because the report is not a report on the proposition at issue; 3. Because the report is inconsistent with the facts and is mislead-

ing; and, 4. Because it is an *ex parte* report and objectionable in spirit and motive."

The President then called for the report of the commission, which was read by its chairman, Dr. E. C. Seguin. The more important features of this report were as follows:

After a plan of proceedings had been agreed upon between the commission and Dr. Stevens, the members began to send patients to the latter in April, 1887.

Each patient was examined by two neurologists, who agreed upon the diagnosis and compiled a history of the case. The patient was then sent with the history to Dr. Stevens, who examined the ocular conditions. Subsequently, the ophthalmologists of the commission examined the eyes and reported their results to the secretary, who added these notes to the copy of the history in his possession. When an operation was undertaken, notice of it was sent by Dr. Stevens to the secretary, who, in turn, notified the ophthalmological members and also the neurologist who had furnished the patient. These members then attended the operation and noticed the conditions found in the eyes before and after it, sending their records to the secretary. Their non attendance, however, did not prevent operations from being done, and the records of these operations, as well as records regarding prisms and glasses prescribed by Dr. Stevens for the patient, the commission had been unable to obtain from him.

The patients from time to time visited the members of the commission by whom they were sent to Dr. Stevens, and notes of the conditions found were made and sent to the secretary. In the cases of epilepsy the record of attacks had not in all cases been kept in duplicate, Dr. Stevens having the record on the blanks furnished by the commission, and in these cases the records had not been accessible.

The total number of patients examined by the commission and sent to Dr. Stevens for examination was 28; 23 epileptics and 5 cases of chronic chorea.

All were found to have ocular insufficiencies. 5 were withdrawn without treatment; 3 a month after examination; 1 two months after; 1 three months after; 2 four months after; 1 five months after.

The reasons for withdrawal were as follows: 5 were unable to attend regularly; 2 were declined by Dr. Stevens on the ground of organic disease; 5 were withdrawn by mutual consent of member sending case and Dr. Stevens for satisfactory reasons, such as non-attendance; 3 were discontented because of increase of symptoms.

Hence, of the 28 cases there were only 14 who were treated for four months or over, and these were the only ones available for conclusions. These cases were tabulated, and the results summarized thus:

	Cured.	Much Improved.	Improved.	Unimproved	Unknown.	Total.
Chorea .	None.	1	2	2	0	5
Epilepsy .	"	None	3	5	1	9
Total .	None.	1	5	7	1	14

Of the six improved cases three had been presented to the commission by Dr. Stevens from his private practice, with no exact data, and the degree of improvement could not be ascertained. In the other three reported as improved, in one improvement began after thirty weeks, and the patient had never been entirely free from chorea for one month; she had at times been better under the ocular treatment, at times worse, even now having choreic movements, usually before menstruation. In another the chorea was only slightly less than at the outset. The sixth case, an epileptic, was having about the same number of attacks as she had had under bromide treatment, but far less than when under no treatment whatever.

Regarding those not improved, many of the patients would say they felt better, in spite of the written records proving the increased frequency of the attacks. This was in part due to increased hope and confidence in the success of the treatment, and also to the freedom from depression of mind and bodily functions produced formerly by the use of the bromides. Others had complained much of headache and vertigo which had appeared during the treatment, and in several diplopia had been produced and still remained. A few of the patients had been made exceedingly miserable by great increase in the frequency and severity of the attacks, which had finally necessitated an abandonment of the ocular treatment and a return to drugs. This statement applied to a number of cases which had been withdrawn.

It would be noticed that none of the cases having been cured, all remained indefinitely under treatment, a perfect permanent ocular equilibrium not having been secured in any case. If it were impossible to secure such equilibrium, a cure could not be expected, granting the theory of Dr. Stevens. If it were possible to secure such equilibrium, it was to be supposed that it could be secured in at least two years; yet four of these cases had been under constant treatment for two and a half years without this result.

In conclusion the committee expressed the opinion that as far as this investigation had warranted a conclusion, the method of Dr. Stevens does not afford a sufficient degree of relief to patients suffering from chorea and epilepsy to warrant its adoption or recommendation to the members of the Neurological Society as a means of cure or as the sole therapeutic measure in such cases.

Dr. Stevens then read a reply to the report of the commission, of which only the outline can be reproduced here. He said that whatever might have been the original condition of the majority of the cases sent to him during the first year, they had long ceased to be cases of functional disease. While, as a matter of fact, all of the patients were incurable with any of the ordinary methods of treatment, and while they had grown worse under such treatment continued during many years, they had in every instance, under his treatment, materially improved in general health and in the diseases for which they were treated. All this improvement had been brought about without recourse to the depressing effects of bromides or the toxic effects of enormous doses of arsenic.

The commission, according to Dr. Stevens, entered upon its work in a manner entirely inconsistent with the true spirit of inquiry. It pursued it in a manner calculated to induce vexation, misunderstanding, and controversy. It occupied many months in securing a few cases, and has never yet complied with its own stipulations. It has through more than two years been occupied in selecting the most unfavorable cases for treat-

ment, and has taken the favorable cases to itself. The spirit of the report is calculated to produce prejudice and to mislead, and the report was made in violation of every principle of right or fairness. The report is represented as an investigation of two diseases, and not of a principle, in direct violation of the pledges of the commission. The commission repeatedly sent cases well known to be unsuitable for the inquiry and contrary to the articles of agreement and the private promises of members, and in this report paraded these cases in long detail with the effect of misleading the judgment of those unacquainted with the facts. It reported the results of treatment of the cases by minimizing the importance of the malady at the beginning of treatment and by magnifying the unfavorable conditions now existing. The results represented are not in conformity with the actual facts, but are grossly at variance with them. It reported as resulting from treatment unfavorable ocular conditions which do not exist, and in this respect made mistakes which should have been avoided.

In the discussion which followed, DR. HAMMOND said that he had seen eight of the cases described, the day before the meeting. The patients and their friends all admitted that the cases had been improved very much by Dr. Stevens' treatment, a fact which was at great variance with the statements made by the same patients to the commission.

DR. SEGUIN said that that part of Dr. Stevens's remarks which reflected upon the fairness and integrity of the commission needed no reply, the names of the members of the commission being a sufficient answer. Dr. Stevens's statements as to the evil effects of the arsenical treatment of chorea and of the bromides in epilepsy were altogether unwarranted by fact.

It was true that the commission had the greatest difficulty in inducing patients to undergo the treatment, but their failure to obtain twelve cases within the first few weeks was not through neglect or violation of the agreement. It was simply an impossibility to supply the necessary material in a given time—enough had been furnished in all. Dr. Stevens, in not furnishing data as to the course and progress of the cases, had violated the compact.

As far as his own cases were concerned, one had been nearly killed by the ocular treatment, which involved the omission of bromides. Another had been under ocular treatment for fifty-two weeks before improvement became marked. Another, a girl with chorea, showed no tangible improvement until after the lapse of seven months. His own experience in cases of chronic chorea, even when of five to seven years' duration, was that they were not merely improved very soon under arsenical treatment with rest in bed, but, as a rule, cured in from two to three months. This girl, though improved under the ocular treatment, had now transient diplopia for far and near, while the second case alluded too saw double on looking to the right. The improvement in these cases (which were the best of the series) could not, therefore be ascribed to the ocular treatment, but was to be attributed to improved health and time. Dr. Stevens had reported fifty per cent. of *cures* of epilepsy in his own (former) series of cases, but in the cases examined by the commission there was not one. Moreover, he had reported his cures taking place in a few weeks after beginning the ocular treatment, while in these cases, where improvement of any kind had taken place, many months had been required before decided change had been manifested.

DR. STARR, in regard to the remarks made by Dr. Hammond, referred to the records of the cases already read to the Society, which demonstrated in each case an increase in the number of attacks, in some of them to three times as many as formerly.

In one case, pronounced by Dr. Webster as normal ophthalmologically, and in every respect a purely functional case, Dr. Stevens claimed to have found optic atrophy, and called it an organic disease.

DR. BIRDSALL had seen one of the epileptics mentioned by Dr. Hammond as having reported improvement to him, and whose sister corroborated the patient's statement. He had asked the sister why she had made this statement. She had replied that she did not refer to the number of fits, which was unchanged, but meant that the patient seemed to be brighter without the bromides. The record showed, however, that the number of attacks had increased, and that the patient was in reality much worse under Dr. Stevens's treatment.

DR. DANA said he had been appointed on the commission by Dr. Stevens himself, and felt that he represented him in a measure, but naturally his chief object had been to obtain the exact truth in the matter. He had sent twelve cases of his own to Dr. Stevens, and had tried hard to get others to go; but he had seen no case much improved under Dr. Stevens's treatment.

DR. STEVENS said that when the investigation was commenced cases were accepted by the commission which ought never to have been taken. One was a pronouncedly organic case, and, in fact, not one of the cases was functional. The operative technique is exceedingly delicate and difficult, and such great skill is required that he himself did not yet claim to have attained perfection; but the more skilful the operator becomes, the more valuable will prove to be this therapeutic measure.

DR. L. C. GRAY did not believe that Dr. Stevens had substantiated his serious charges against the commission or caused any particular improvement in the cases. Esquirol showed in 1828 that temporary improvement took place in all cases of chronic epilepsy in La Salpétrière when treated by drugs known at that day. A decrease of from six to three fits daily could not be considered a permanent improvement, because such decrease was often spontaneous, and in some cases fits spontaneously ceased for years. He agreed with Dr. Seguin, that where improvement did not begin before fifty-two weeks after treatment had been begun, any improvement that might take place could not fairly be ascribed to the measure employed.

DR. SEGUIN said, with reference to the work done by Dr. Stevens, that all of the members of the commission had appreciated it highly, and had felt like adding something commendatory of his skill to the report, but refrained from doing so because, under the circumstances, it might have appeared hypercritical, and was really alien to the subject assigned to the commission, viz., the determination of results.

DR. J. L. CORNING thought that Dr. Dana's tribute to the good work done by Dr. Stevens was in exceedingly good taste. Dr. Stevens's work was unusually scientific

and original, and there seemed to be very little of that sort of work done in New York, where compilation and the importation of foreign ideas were the order of the day. Hence, this discovery of Dr. Stevens ought to meet with wide recognition.

A motion to adopt the report of the commission was then carried by a vote of five to four out of the eighteen members present, the members of the commission refraining from casting their votes.

The following motion, made by Dr. Amidon, was unanimously carried:

"That the thanks of the Society be extended to Dr. Stevens for the assiduous labor he has devoted to the work of the commission, and that the Society assure Dr. Stevens that it highly appreciates the ingenuity and technical skill he has shown in the prosecution of his method."

CORRESPONDENCE.

SNAKE POISON AND ITS ANTIDOTE.

To the Editor of THE MEDICAL NEWS,

SIR: Some dozen people have sent me slips from the western papers as to specifics for snake bites. This nonsense about a remedy which is none at all, is a serious thing, and as some of those who write me are intelligent men, I enclose a note from one whose practical acquaintance with snakes none will dispute. All over our country are to be found, here and there, remedies reputed of value. I tested many, but always failed. I advise some of my too numerous correspondents to re-read my paper. They will find that it answers most of their queries. Very truly yours,

S. WEIR MITCHELL.

The following, one of the many slips spoken of, is taken from the New York *Tribune* of November 7, 1889:

"LOS ANGELES, CAL., Nov. 7.—Hereafter, when camping-out parties are formed, the demijohn full of snake-bite cure will have to be replaced by a bundle of weeds, for T. R. Fisher, an old citizen of Santa Barbara, who is familiar with the habits of the California Indians, claims to have found out their remedy for rattlesnake bites, which is a species of the plant Euphorbia. Dr. S. Weir Mitchell, of Philadelphia, recently stated, in an article which has been copied by the California press, that no specific was known for the virus of the rattlesnake. Mr. Fisher saw this statement and contradicted it, saying that the plant referred to was a sure cure, and he even goes so far as to state that the snakes themselves, when bitten, will make use of the remedy. This receives corroboration from Frank Smith, who lives at Whitewater, in San Bernardino County, on the edge of the Desert. He speaks most of the Indian dialects. The weed, he says, is a Euphorbia, and is common through California and Arizona. It is a vine-like plant, radiating from a centre, growing close to the earth; the leaf resembles the clover, but is less than half as large. When a stem is broken a milky exudation follows, similar to that of the 'milkweed' of the East. Mr. Smith gives this as the method of application: The green weed should be macerated in water, the skin about the bite scarified, and the pulpy mass of the plant placed on it and rubbed well into it; this should be repeated at intervals for fifteen or twenty minutes, and then a poultice of the same plant should be bound on and left. Mr. Smith holds that within forty-eight hours all symptoms of poison will disappear. So confident is he that, in *The Banning Herald*, he offers to settle the discussion with Dr. Mitchell in the Western style, by offering to bet $500 to $1,000 that with the Euphorbia he can cure any case of rattlesnake bite, and he will allow Dr. Mitchell to pick out his own snake. The Mexicans know the weed, and call it Golondrina."

DEPARTMENT OF STATE.
INTERNATIONAL AMERICAN CONFERENCE.
WASHINGTON, November 24, 1889.

DR. S. WEIR MITCHELL,

DEAR SIR: The above is an old story, known to army officers and others for many years. I heard all that was to be said about it in 1869, and so stated in my article "Snake Dance of the Moquis of Arizona."

Surgeon B. J. D. Irwin, U. S. A., has published a monograph on the "Euphorbia Prostrata" ("Golondrina" of the Mexicans, "milkweed" of Americans). It has been used, to my knowledge, by Mexicans and by Pinea and Apache Indians, but it is uncertain in effect and in no sense to be called a sure cure.

I remember an Apache boy who was treated by his own medicine-men; the leg in which the bite was, became paralyzed, atrophied and, I think, ulcerated: boy lived (Old Camp Grant, Arizona, 1870).

Another case, a dog; treated for rattleskake bite in neck; death did not occur for six weeks, but sloughing ulceration began, and ended fatally (Valley of Gila, 1871).

A third case—government mule bitten on muzzle—no benefit at all (Canon of Salt River, December, 1872). In the last instance, Golondrina was mashed up with human urine.

Please excuse my hurried letter, which may or may not contain facts already known to you.

Very truly yours,

JOHN G. BOURKE,
Captain 3d Cavalry,
U. S. Army.

NEWS ITEMS.

Academy of Medicine Election.—The New York Academy of Medicine at its meeting on January 2d elected the following officers: Vice-President, R. C. M. Page; Trustee, Lawrence Johnson; Members of Committee on Admissions, Augustus Caille and Thomas R. French; Member of Committee on Library, Egbert H. Grandin. Dr. W. G. Wylie read a paper on the treatment of surgical peritonitis, which was followed by a discussion.

The Christ Hospital of Cincinnati.—The *Lancet-Clinic* announces the inauguration of a new hospital at Cincinnati with the above title. It will be under the guidance of the Methodist Episcopal Church, but non-sectarian in its charity. This is the second hospital to be founded by that Church in this country, the first one being the Seney Hospital, of Brooklyn. Dr. C. G. Comegys is the senior consultant and chief director in the new Christ's Hospital.

New Appointment.—At a meeting of the Board of Managers of St. Luke's Hospital, New York City, held De-

cember 27, 1889, Dr. T. Halsted Myers was appointed Attending Orthopædic Surgeon to the Hospital.

To Restrict Quackery in Maryland.—At a meeting of the Medical and Chirurgical Faculty of Maryland on January 2d, a bill was framed to be presented to the Legislature for the protection of the people from ignorant and fraudulent practitioners, and for the elevation of the profession in Maryland. The bill provides for a board of twelve medical examiners, nine to be selected from the regular physicians and three from the homœopathists. The appointments are to be made by the Governor; the regulars on the recommendation of a general convention of the schools, and the homœopathists on the recommendation of the State Homœopathic Society. The diploma of a college will not be accepted, and the applicant for license to practise must pass an examination in materia medica, therapeutics, and other branches of medicine. The board shall have the power of revoking the license of physicians given to inebriety, and also of persons advertising to cure special diseases which in the judgment of the board are incurable.

Physicians form a Trust.—It is stated that the doctors of Findlay, Ohio, have formed a "trust," and advanced the price of professional visits from $1 to $1.50 each. The announcement has caused great indignation among the people, as influenza is epidemic. It is charged that the physicians took advantage of the necessity which exists for their services.

Typhus Fever in New York.—Three or four cases of typhus fever have been discovered in the North Brother's Island Hospital of New York City. The infection is believed to have been imported on the steamship "Westernland" by means of the baggage of some German immigrants. An effort will be made to trace the course of each passenger, and their future medical history until the period of typhus incubation shall have expired.

The Presbyterian Hospital of New York.—The recent fire in the north building of the Presbyterian Hospital, New York, has proved a stimulus to the friends of the institution. It is reported that an anonymous donor has promised $250,000 for immediate use if other contributors will subscribe a like amount. The out-patient department of the Hospital, formerly used as a chapel, and the dispensary have been converted into temporary wards, with sixty beds, so that nearly all the former patients can be accommodated.

Obituary.—DR. LEWIS H. SAYRE, of New York, the son of Dr. Lewis A. Sayre, died suddenly on January 3d in his thirty-eighth year. Since his graduation from Bellevue Hospital Medical College in 1876 he had been associated with his father in private practice and college work. Death is supposed to have been caused by cardiac disease.

——— DR. GEORGE W. LAWRENCE, who died at Hot Springs, Arkansas, December 30th, was the senior resident physician of that place. He was born at Plymouth, Pa., in 1823, and graduated from the University of Pennsylvania in 1846. He went to California in 1849, and was on Governor McDougal's surgical staff in 1850. During the late war he became Medical Director in the Confederate service, and occupied other responsible offices until June, 1865. His residence at Hot Springs dates from 1859. His early life was eventful and somewhat adventurous, while his later years were replete with responsibilities and many well-earned favors.

——— DR. BREHMER, of the well-known Sanitarium for Consumptives at Göbersdorf, died on the 22d ult., from inflammation of the lungs, following a cold caught during a Christmas shopping trip to Breslau. In all probability he was a victim to the prevalent epidemic.

Post-graduate Instruction in London.—The clinical course of instruction for graduates begins its first term on January 13, Dr. Octavius Sturges opening it at the Great Ormond Street Hospital on the acute lung affections of infancy. Among the other physicians who will teach in this first course, are Drs. Bastian, Barlow, Buzzard, Beevor, J. K. Fowler, Gowers, T. H. Green, Hadden, Kidd, Angel Money, Ormerod, J. F. Payne, F. T. Roberts and C. Theodore Willians. On the surgical staff there will be Mr. Jonathan Hutchinson, president of the organization, and Messrs. Brudenell Carter, Marcus Gunn, Victor Horsley, W. Lang, J. H. Morgan, Edmund Owen, Bernard Pitts and A. Q. Silcock. Dr. J. Fletcher Little, Cavendish Square, is the secretary. The fee will be nine guineas for a course of seventy lectures, extending over a period of nine weeks.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM DECEMBER 30, 1889, TO JANUARY 6, 1890.

By direction of the Secretary of War, the leave of absence granted E. A. MEARNS, *Captain and Assistant Surgeon*, in S. O. 244, October 19, 1889, from this office, is extended two months.—*S. O. 303, A. G. O.*, December 30, 1889.

By direction of the Secretary of War, Par. 1, S. O. 180, Department of the Missouri, December 6, 1889, transferring NATHAN S. JARVIS, *First Lieutenant and Assistant Surgeon*, from Fort Lewis, Colorado, to Camp Wade, Kingfisher, Indian Territory, is confirmed.—Par. 6, *S. O. 303, A. G. O.*, December 30, 1889.

By direction of the Secretary of War, the leave of absence granted JULIAN M. CABELL, *First Lieutenant and Assistant Surgeon*, in S. O. 249, A. G. O., October 25, is extended one month.—*S. O. 304, A. G. O.*, December 31, 1889.

By direction of the Secretary of War, ordinary leave of absence for two months is granted JUNIUS L. POWELL, *Captain and Assistant Surgeon*, in extension of the leave of absence on account of sickness, granted him in S. O. 258, November 5. 1889, from this office.—Par. 1, *S. O. 1, A. G. O.*, January 2, 1890.

OFFICIAL LIST OF CHANGES IN THE STATIONS AND DUTIES OF THE MEDICAL CORPS OF THE U. S. NAVY, FOR THE WEEK ENDING JANUARY 4, 1890.

CLARK, JOHN H., *Medical Inspector.*—Ordered to the U. S. S. "Baltimore."

DIEHL, OLIVER, *Passed Assistant Surgeon.*—Ordered to the U. S. S. "Baltimore."

STITT, E. R., *Assistant Surgeon.*—Ordered to the U. S. S. "Baltimore."

SMITH, HOWARD, *Surgeon.*—Ordered to the U. S. S. "Alliance."

GATEWOOD, J. D., *Passed Assistant Surgeon.*—Ordered to the U. S. S. "Despatch."

TRYON, J. R., *Surgeon.*—Ordered to the Naval Medical Examining Board.

SCOFIELD, W. K., *Medical Inspector.*—Ordered to special duty at New York City.

GUITERAS, D. M., *Passed Assistant Surgeon.*—Ordered to the Naval Hospital, Philadelphia, Pa.